DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

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Subchapter 1

Medical Assistance

37.82.101 MEDICAL ASSISTANCE, PURPOSE AND INCORPORATION OF POLICY MANUALS (1) Subject to applicable state and federal laws, regulations and rules, the Montana medicaid program pays for covered medically necessary services for persons determined eligible by the department or its agents.

(2) The department adopts and incorporates by reference the state policy, namely the Family Medicaid Manual and the SSI Medicaid Manual manuals governing the administration of the medicaid program effective July 1, 2005. The Family Medicaid Manual, the SSI Medicaid Manual and the proposed manual updates are available for public viewing at each local office of public assistance or at the Department of Public Health and Human Services, Human and Community Services Division, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952. The proposed manual updates are also available on the department's website at www.dphhs.mt.gov/legalresources/proposedmanualchange.shtml. (History: 53-2-201 and 53-6-113, MCA; IMP, 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 476; AMD, 2002 MAR p. 1771, Eff. 6/28/02; AMD, 2003 MAR p. 15, Eff. 1/17/03; EMERG, AMD, 2003 MAR p. 652, Eff. 4/11/03; AMD, 2003 MAR p. 1301, Eff. 7/1/03; AMD, 2004 MAR p. 200, Eff. 1/30/04; AMD, 2005 MAR p. 163, Eff. 1/28/05; AMD, 2005 MAR p. 1591, Eff. 8/26/05.)

37.82.102 MEDICAL ASSISTANCE, DEFINITIONS (1) "AABD" means aid to the aged, blind and disabled under Title XVI of the Social Security Act.

(2) "AB" means aid to the blind under Title X of the Social Security Act.

(3) "AFDC" means aid to families with dependent children under Title IV-A of the Social Security Act.

(4) "Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

(5) "APTD" means aid to the permanently and totally disabled under Title XIV of the Social Security Act.

(6) "Categorically needy" means aged, blind or disabled individuals or families and children:

(a) who are otherwise eligible for medicaid and who meet the financial eligibility requirements of section 1951 of the Social Security Act, SSI, or an optional state supplement; or

(b) whose categorical eligibility is otherwise provided for in ARM Title 37, chapter 82, subchapters 7, 9, 11, and 13.

(7) "Certification" means the process by which a governmental or non-governmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined standards.

(8) "Department" means the Montana department of public health and human services.

(9) "Designated review organization" means either the department or other entity, contracting with the department or designated by law to determine the medical necessity of medical services rendered to recipients of public assistance.

(10) "Electronic media claims" means claims submitted to the Montana medicaid program via magnetic tape or another acceptable electronic media approved by the department in accordance with ARM 37.85.406.

(11) "Emergency service" means inpatient and outpatient hospital services that are necessary to treat an emergency medical condition as defined in 42 CFR 489.24(b).

(12) "Families and children" refers to eligible members of families with dependent children who are financially eligible under family-related rules in subchapters 7, 11, and 13. In addition, this group includes individuals under 19 who are not dependent children but who are financially eligible under the above-cited subchapters. It does not include individuals under age 21 whose eligibility for medicaid is based on the blindness or disability; for these individuals, the SSI-related rules in ARM Title 37, chapter 82, subchapters 9, 11, and 13 apply.

(13) "Family size", for SSI-related medically needy, means the number of eligible individuals and responsible relatives living in the same household unit. Ineligible persons living in the same household who are not responsible relatives are not counted when determining family size. For family-related medically needy, "family size" means the number of eligible individuals in the same household unit. Ineligible persons living in the same household, including ineligible responsible relatives, are not counted in determining family size.

(14) "Fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

(15) "Grounds for sanctions" are fraudulent, abusive, or improper activities engaged in by providers of medical assistance services.

(16) "Intern" means a medical practitioner involved in a period of on-the-job training as part of a larger educational program.

(17) "License" means permission granted to an individual or organization by competent authority to engage in a practice, occupation or activity which would otherwise be unlawful. It is granted in the state where the practice, occupation or activity is carried out.

(18) "Medically necessary service" means a service or item reimbursable under the Montana medicaid program, as provided in these rules:

(a) which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

(i) endanger life;

(ii) cause suffering or pain;

(iii) result in illness or infirmity;

(iv) threaten to cause or aggravate a handicap; or

(v) cause physical deformity or malfunction.

(b) A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.

(c) Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana medicaid program.

(i) Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the U.S. department of health and human services, including the medicare program, or the department's designated review organization or procedures and items approved by the U.S. department of health and human services for use only in controlled studies to determine the effectiveness of such services.

(19) "Medically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for medicaid and whose income is above the prescribed limits for the categorically needy but within the limits prescribed in ARM Title 37, chapter 82, subchapter 11.

(20) "Montana medicaid program" means the Montana medical assistance program authorized by Title 53, chapter 6, MCA and Title XIX of the Federal Social Security Act.

(21) "OAA" means old age assistance under Title I of the Social Security Act.

(22) "OASDI" means old age, survivors, and disability insurance under Title II of the Social Security Act.

(23) "Optional state supplement" means a cash payment made by the department to an aged, blind or disabled individual.

(24) "Professional component" means the cost of professional services of the physician including examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and reporting of the examination and consultation of the referring physician. It does not include the cost of personnel, materials, equipment or other facilities.

(25) "Provider" means an individual, company, partnership, corporation, institution, facility, or other entity or business association that has enrolled or applied to enroll as a provider of services or items under the Montana medicaid program.

(26) "Recipient overpayment" means an amount of public assistance paid to or on behalf of a recipient in excess of the amount that is proper.

(27) "Resident" means a medical practitioner involved in a prolonged period of on-the-job training which may either be part of a formal educational program or be undertaken separately after completion of a formal program, sometimes in fulfillment of a requirement for credentialing.

(28) "Services" means services, items and any other amounts reimbursable under the Montana medicaid program.

(29) "SSI" means supplemental security income under Title XVI of the Social Security Act.

(30) "Suspension of participation" means an exclusion from participation in the medicaid program for a specified period of time.

(31) "Suspension of payments" means the withholding of all payments due a provider pending the resolution of the matter in dispute between the provider and the department.

(32) "Technical component" means the cost of personnel, materials including visual contrast media and drugs, space, equipment and other facilities, but does not include the cost of radioisotopes.

(33) "Termination from participation" means an exclusion from participation in the medicaid program.

(34) "Total value" means the combined value of the professional component and the technical component of physician services.

(35) "Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1980 MAR p. 2978, Eff. 11/29/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 769, Eff. 7/31/81; AMD, 1982 MAR p. 105, Eff. 1/29/82; AMD, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1983 MAR p. 757, Eff. 7/1/83; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1985 MAR p. 248, Eff. 3/15/85; AMD, 1985 MAR p. 1409, Eff. 9/27/85; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1986 MAR p. 1967, Eff. 12/1/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1988 MAR p. 753, Eff. 5/1/88; AMD, 1991 MAR p. 2049, Eff. 11/1/91; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 495, Eff. 2/13/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2003 MAR p. 15, Eff. 1/17/03.)

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Subchapter 2

Application, Determination and Redetermination of Eligibility and Furnishing Assistance

37.82.201 APPLICATION (1) Opportunity to apply:

(a) Any individual wishing to do so will be afforded the opportunity to apply for medicaid without delay.

(2) Written application and place of application:

(a) The application must be submitted in writing:

(i) on the form and in the manner prescribed by the department of public health and human services; and

(ii) at the office of public assistance in the county of their choice.

(3) Assistance with application:

(a) An application will be accepted from a person acting responsibly on the behalf of a client who is:

(i) incompetent;

(ii) incapacitated; or

(iii) otherwise incapable of submitting the application himself.

(b) An individual or individuals of the applicant's choice may accompany, assist and represent the applicant in the application process.

(4) Automatic entitlement to medicaid:

(a) Except as provided for below, a separate application for medicaid will not be required from an individual if the individual receives:

(i) supplemental security income (SSI);

(ii) mandatory state supplement; or

(iii) optional state supplement.

(b) Recipients of SSI, mandatory state supplement and optional state supplement must provide on the form and in the manner prescribed by the department, information on third party liability as a further condition of eligibility.

(5) Availability of program information:

(a) The following information will be made available in the form of brochures, pamphlets and other appropriate printed materials, to all applicants and all other individuals who request it:

(i) the eligibility requirements;

(ii) available medicaid services;

(iii) the rights and responsibilities of the applicant/recipient; and

(iv) the rules governing appeals of department decisions.

(6) Use of social security number (SSN):

(a) In the Montana medicaid program, disclosure of or application for a social security number is mandatory. Medicaid may be denied to an otherwise eligible applicant for failure or refusal to disclose or apply for a SSN.

(b) Notwithstanding the above, under P.L. 98-369, Sec. 2651(c)(3) and 53-2-201, MCA, the department will request, on the application, the SSN of each individual (including children) for whom medicaid services are requested.

(c) In requiring a SSN, the department will inform the applicant that:

(i) disclosure of or application for a SSN is mandatory;

(ii) the mandate for a SSN is made under the authority of P.L. 98-369, Sec. 2651(c)(3) and 53-2-201, MCA; and

(iii) the SSN will be used only in the administration of the medicaid program. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-132 and 53-6-133, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1985 MAR p. 1574, Eff. 10/18/85; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2003 MAR p. 15, Eff. 1/17/03.)

Rules 02 and 03 reserved

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37.82.204 DETERMINATION OF ELIGIBILITY (1) Timely determination of eligibility:

(a) Aid will be furnished in a timely manner to eligible persons and will conform to the following time standards:

(i) 90 days for applicants on the basis of disability; and

(ii) 45 days for all other applicants.

(b) These time standards cover the period from the date of application to the date the department mails or otherwise provides the applicant with a formal written notice of decision.

(c) Eligibility will be determined within the time standards except in cases of unusual circumstances which are caused by the claimant or which are beyond the department's control.

(d) The time standards will not be used:

(i) as a waiting period before determining and announcing eligibility; or

(ii) as a reason for denying eligibility because it has not been determined within the time standard.

(2) Denials or determinations of disability made by the U.S. social security administration (SSA) will be accepted by the department unless one of the following conditions exist:

(a) the individual has not applied to SSA for supplemental security income (SSI) cash benefits, or is found ineligible for SSI for a reason other than a disability;

(b) the individual has applied both to SSA for SSI and to the department for medicaid, but SSA has not made a disability determination within 90 days from the date of the individual's application for medicaid; or

(c) the individual has applied for medicaid as a non-cash recipient; and

(i) alleges a disabling condition different from, or in addition to that considered by SSA in making its determination; or alleges more than 12 months after the most recent SSA determination denying disability that his condition has changed or deteriorated since that SSA determination and further alleges a new period of disability which meets the durational requirements of the Social Security Act, and has not applied to SSA for a determination with respect to these allegations; or

(ii) alleges less than 12 months after the most recent SSA determination denying disability that his condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Social Security Act and has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations.

(3) Determinations of disability will be made in accordance with the requirements applicable to disability determinations under the Supplemental Security Income Program specified in 20 CFR, part 416, subpart I (1993). The department hereby adopts and incorporates by reference 20 CFR, part 416, subpart I (1993). A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Developmental Disabilities Program, 111 Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(4) If the department bases its disability determination upon the decision made by the social security administration (SSA) the medicaid applicant is limited to appealing the decision through the SSA procedures for hearing and appeals. If the department makes a decision of disability on its own as set forth under the circumstances stated in (2) of this rule, the medicaid applicant has a right of appeal through the department's fair hearing process.

(5) Adequate notice:

(a) Each applicant will be sent a written notice of the department's decision on his application.

(b) If eligibility is denied, written notice will include the reasons for the action, the specific regulation or statute supporting the action, and an explanation of the applicant's right to request a hearing and will be mailed or otherwise provided to the applicant no later than date of denial.

(6) Disposal of applications:

(a) Each application will be disposed of by a finding of eligibility or ineligibility, unless:

(i) the applicant voluntarily withdraws his application;

(ii) the applicant dies and no one acting responsibly on his behalf requests in writing to have the application continued; or

(iii) the applicant cannot be located.

(b) Voluntary withholding of information that is mandatory for eligibility determination by the applicant will result in a finding of ineligibility.

(7) Effective date:

(a) Eligibility for medicaid will be effective as provided below, if the individual was or if he had applied would have been eligible for medicaid.

(i) "if he had applied" includes if someone had applied for him; also, the individual need not be alive when application for medicaid is made on his behalf.

(b) For coverage of aged, blind and disabled persons whose eligibility is related to the supplemental security income program, eligibility is granted for the month provided the resource eligibility criteria is met the first moment of the first day of that month and all other eligibility criteria are met for that month.

(c) For coverage of parents and children whose eligibility is related to the FAIM financial assistance program, eligibility is granted for the month if all eligibility criteria are met on the date of application and first day of subsequent month.

(d) For coverage of medically needy persons, eligibility begins:

(i) on the first of the month when the medically needy person pays the cost-share amount as defined in ARM 37.82.1107; or

(ii) when incurred remedial and medical expenses equal the required incurment as defined in ARM 37.82.1107 for the period.

(e) In no case will coverage be granted prior to the first day of the third month preceding the date of application. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, 53-6-132 and 53-6-133, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1985 MAR p. 181, Eff. 2/15/85; AMD, 1986 MAR p. 678, Eff. 4/25/86; AMD, 1993 MAR p. 1398, Eff. 7/1/93; AMD, 1994 MAR p. 36, Eff. 1/14/94; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.205 REDETERMINATION OF ELIGIBILITY (1) Periodic redetermination of eligibility:

(a) where an individual has been determined eligible, eligibility will be reconsidered or redetermined:

(i) at the time required when the department has information obtained previously about anticipated changes in the individual's situation which might affect eligibility;

(ii) within 30 days after a report is obtained which indicates that changes in the individual's circumstances may affect the individual's eligibility; and

(iii) at least every six months if the client is categorically eligible related to FAIM financial assistance; or

(iv) at least every 12 months if the client is categorically eligible related to SSI.

(2) The department will provide recipients with timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under medicaid.

(a) Timely notice is as defined in ARM 46.2.204.

(3) In redetermining eligibility, the department will also review case records for the recipient's SSN or, in the case of families, each family member's SSN. If the case record does not contain the SSN's, the department will require them in accordance with ARM 37.82.201(6). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-142, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1986 MAR p. 678, Eff. 4/25/86; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.206 FURNISHING ASSISTANCE (1) The department will:

(a) furnish medicaid in a timely manner to recipients, as required by ARM 37.82.204(1)(a), without any delay caused by the agency's administrative procedures;

(b) continue to furnish medicaid regularly to all eligible individuals;

(c) make arrangements to assist applicants and recipients to get emergency medical care whenever needed. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-132 and 53-6-133, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

37.82.207 RECIPIENT OVERPAYMENTS (1) The department shall take reasonable and appropriate actions to recover each recipient overpayment, as defined in ARM 37.82.102, of medicaid benefits when the recipient overpayment is the result of the recipient's intentional or unintentional act or omission. The department shall also take reasonable and appropriate actions to recover overpayments that result from continued benefits which were paid pending the outcome of a fair hearing that is ultimately decided, at least in part, in the department's favor.

(2) The department shall not seek to recover a recipient overpayment, as defined in ARM 37.82.102, of medicaid benefits when the entire recipient overpayment is the result of an error made by the department.

(3) A recipient overpayment shall be calculated to include:

(a) the total amount of medicaid benefits paid to or on behalf of an ineligible recipient; or

(b) the difference between the amount of an accurately calculated monthly incurment and the amount of monthly incurment the recipient paid toward an incorrectly calculated incurment.

(4) The medicaid recipient and any other individual who has a legal obligation to support the medicaid recipient is liable to the department for any recipient overpayment sought to be recovered by the department. The department may use all legal means to recover the overpayment. (History: Sec. 53-2-201, 53-4-212 and 53-6-113, MCA; IMP, Sec. 53-6-111, MCA; NEW, 2003 MAR p. 15, Eff. 1/17/03.)

Subchapter 3 reserved

Subchapter 4

General Non-Financial and Financial Eligibility Requirements for the Categorically Needy and the Medically Needy

37.82.401 CITIZENSHIP AND ALIENAGE (1) As a condition of eligibility for medicaid, an otherwise eligible individual must be either:

(a) a citizen of the United States; or

(b) a qualified alien as defined in ARM 46.18.140 lawfully admitted for permanent residence or who entered the U.S. after August 22, 1996, otherwise permanently residing in the United States, including any alien who is lawfully present in the United States under authority of sections 203(a)(7) or 212(d)(5) of the Immigration and Nationality Act.

(c) a non-citizen legal alien living in the U.S. prior to August 23, 1996. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.402 RESIDENCY (1) For purposes of this rule, a person is considered incapable of indicating intent if:

(a) his I.Q. is 49 or less or he has a mental age of seven or less, based on standardized tests;

(b) he has been judged legally incompetent; or

(c) documentation acceptable to the department supports a finding that he is incapable of indicating intent. Acceptable documentation includes but is not limited to medical, psychological or psychiatric reports prepared by a qualified professional person.

(2) Medicaid will be provided to otherwise eligible residents of Montana.

(a) Noninstitutionalized individuals:

(i) An individual age 18 and over is a resident if he is living in Montana with the intent to remain permanently or for an indefinite period.

(A) there is no durational requirement for residency;

(B) residency is retained until abandoned; and

(C) temporary absences from Montana with intent to return when the purpose of the absence is accomplished does not interrupt continuity of residence.

(ii) An individual under age 19 living with a caretaker relative who qualifies as a resident of Montana under the criteria of this rule is also considered a resident of the state. Caretaker relative is as defined in ARM 46.10.302.

(iii) A blind or disabled individual under age 21 is considered a resident of Montana if he is living in the state.

(b) Individuals receiving an SSI state supplementary payment:

(i) Any individual receiving a state supplementary payment from Montana is considered a resident of Montana.

(ii) Any individual receiving a state supplementary payment from a state other than Montana is considered a resident of the state making the supplementary payment.

(c) Institutionalized individuals:

(i) An institutionalized individual who became incapable of indicating intent at or after age 18 is a resident of Montana if he was residing in the state when he first became incapable of indicating intent.

(ii) An individual under age 18 or an individual age 18 or older who became incapable of indicating intent before 18 is a resident of Montana if his parents or legal guardian resides in the state or, when the parents live in separate states and there is no legal guardian appointed, if the parent applying for medicaid on his behalf resides in Montana.

(iii) Medicaid eligibility may not be denied to an institutionalized individual who did not establish residency in Montana prior to entering the institution.

(d) Out-of-state institutional placements:

(i) Any individual placed in an out-of-state institution by Montana continues to be a Montana resident.

(ii) Any individual placed in a Montana institution by another state continues to be a resident of the placing state.

(3) Montana has entered into an interstate residency agreement with certain other states. This agreement sets forth rules and procedures for resolving cases of disputed residency and takes precedence over the provisions above. A copy of the agreement and list of states involved in the agreement may be obtained from the Department of Public Health and Human Services, 111 Sanders, P. O. Box 4210, Helena, MT 59620-4210. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Rules 03 through 05 reserved

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37.82.406 APPLICANT'S CHOICE OF CATEGORY (1) A person who is eligible for more than one category of medicaid eligibility will have eligibility determined for the category the person selects.

(2) A person who is eligible for medicaid as a qualified medicare beneficiary and under another medicaid eligibility category may have eligibility determined under all categories for which the person may qualify.

(3) "Category" as used in this rule means aged, blind, disabled, families and children or qualified medicare beneficiary. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 476.)

37.82.407 LIMITATION ON THE FINANCIAL RESPONSIBILITY OF RELATIVES (1) Except as provided in (2), only the income and resources of a spouse or, if the individual is an individual who is under age 21 or blind or disabled, of a natural or adoptive parent or, if specifically provided for in subchapters 7, 9, 11 and 13, of a stepparent will be considered available to an individual in determining his eligibility for medicaid. The income and resources of any other relative will not be considered available to the individual.

(2) In the case of an individual applying for or receiving AFDC-related medicaid in the FAIM project, the income and resources of every person included in the same assistance unit as the individual as required by ARM 46.18.113 are considered available to the individual, regardless of whether the income and resources are actually contributed to the individual. Persons whose income and resources are considered available to the individual include, but are not limited to:

(a) Stepparents of a dependent child as defined in ARM 46.18.103.

(b) Siblings, stepsiblings or half-siblings of a dependent child as defined in ARM 46.18.103.

(3) Reimbursement for amounts paid by the department for medical services provided to an individual will be collected only from a spouse or, if the individual is under age 21 or blind or disabled, from a natural or adoptive parent. Reimbursement will not be obtained from any other relative. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1996 MAR p. 284, Eff. 1/26/96; TRANS, from SRS, 2000 MAR p. 476.)

Rules 08 through 14 reserved

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37.82.415 APPLICATION FOR OTHER BENEFITS (1) As a condition of eligibility, applicants and recipients must make every effort to obtain any benefits to which they are entitled, unless they can show good cause for not doing so. These benefits include, but are not limited to, veteran's compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

37.82.416 ASSIGNMENT OF RIGHTS TO BENEFITS, COOPERATION WITH CHILD SUPPORT ENFORCEMENT REQUIREMENTS (1) As a condition of eligibility for medicaid, each legally able applicant and recipient must assign his rights to medical support or other third party payments to the department and must cooperate with the department in obtaining medical support or payments, except as provided in (4)(a) through (4)(e).

(2) Assignment method and rights assigned:

(a) Under 53-2-612, MCA, the department has a lien upon all money paid by a third party or his insurer in satisfaction of a judgement or settlement arising from a recipient's claim for damages or compensation for personal injury, disease, illness, or disability. Under 53-2-613, MCA, by signing the department-prescribed application form for medicaid, an applicant for or recipient of medicaid assigns to the department:

(i) his own rights to any medical care support under an order of a court or an administrative agency, and any third party payments for medical care; and

(ii) the rights of any other eligible individual in the family for whom he can legally make an assignment.

(b) Assignment of rights to benefits does not include assignment of rights to medicare benefits.

(3) Cooperation in establishing paternity and obtaining support:

(a) The individual whose rights are assigned as provided in (2) must cooperate in:

(i) establishing paternity of a child born out of wedlock for whom he can legally assign rights; and

(ii) obtaining medical care support and payments for himself and any other individual for whom he can legally assign rights.

(b) As a part of cooperation, the department may require an individual to:

(i) appear at the state or county office to provide information or evidence relevant to the case;

(ii) appear as a witness at a court or other proceeding;

(iii) provide information, or attest to lack of information, under penalty of perjury;

(iv) pay to the department any support or medical care funds received that are covered by the assignment of rights; and

(v) take any other reasonable steps to assist in establishing paternity and securing medical support and payments.

(c) The department will waive the requirements in (a) and (b) if it determines that the individual has good cause for refusing to cooperate.

(i) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments for a child for whom the individual can legally assign rights, good cause is as defined in ARM 37.78.215.

(ii) With respect to obtaining medical care support and payments for an individual in any case not covered by (3)(c)(i), the department will waive cooperation if the department determines that cooperation is against the best interests of the individual or other person to whom medicaid is being furnished, because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(d) The procedure for waiving cooperation is as provided in ARM 37.78.215.

(4) Individuals receiving medical assistance only in any of the following coverage groups are not required to assign their rights to medical support or cooperate with the child support enforcement division in establishing paternity and obtaining medical support:

(a) automatic newborn assistance;

(b) poverty level child assistance;

(c) poverty level pregnant woman assistance;

(d) poverty six child assistance; and

(e) Ribicoff child assistance.

(5) Medicaid eligibility will be denied or terminated for any applicant or recipient who fails or refuses without good cause to comply with the requirements of this rule regarding assignment of rights and/or cooperation in establishing paternity and obtaining support.

(a) However, medicaid will be provided to a minor child or other individual who cannot legally assign rights or cooperate, if that individual is otherwise eligible, despite the failure or refusal of the caretaker relative or any other individual to comply with the requirements of this rule. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-612, 53-2-613 and 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1990 MAR p. 1609, Eff. 8/17/90; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.417 TRANSFER OF RESOURCES (1) The following definitions apply to this subchapter:

(a) "Fair market value" means the amount of compensation at which property would change hands between a willing buyer and an unrelated seller, neither being under compulsion to buy or sell and both having reasonable knowledge of the relevant facts.

(b) "Compensation" means money, food, shelter, support, maintenance, services or other valuable real or personal property, as further specified in (5), received by an individual in exchange for the transferred property.

(c) "Uncompensated value" means the difference between the property's fair market value at the time of the transfer less any outstanding encumbrances on the property and the fair market value of compensation received in exchange for the property.

(d) "Transfer of property" means any transfer or renunciation of a client's property. Transfers to joint tenancy or to tenancy in common are included in this definition. Transfers of or restrictions upon a client's right of access to or legal ability to dispose of property are also included in this definition, except as provided in (8)(b)(iv).

(e) "Incurred medical expenses" are those actually incurred medical expenses which are not subject to payment by a third party.

(f) "Undue hardship" means any one of the conditions specified in (8)(b)(i) through (8)(b)(v).

(g) "Client" means applicant for or recipient of medicaid services or such a person at any time prior to application and, where the context allows, includes any person whose resources are considered by the department in determining eligibility of the applicant or recipient.

(h) "Property" means any full or proportionate right, title or interest in or to any real or personal property or property right.

(i) "Institutionalization" means admission to a nursing facility, admission to a medical institution at a level of care equivalent to nursing facility services, or commencement of services to the applicant or recipient under the home and community based waiver program.

(j) "Home" means the client's principal place of residence, including adjoining land and outbuildings;

(k) "Principal place of residence" means the property on which the individual, the individual's spouse, or a dependent child of the individual (including a dependent adult child) currently resides or has resided within the previous six months and the individual, the individual's spouse, or a dependent child of the individual intends to return to the property to reside within six months of absence in the event of a temporary absence. Only one property may qualify as an individual's principal place of residence.

(2) The client's home:

(a) is a countable resource; and

(b) will be considered an exempt resource so long as the client or a dependent child resides in the home and ownership is retained by the client.

(3) Property transfers made on or after July 1, 1988, are evaluated for only those clients applying for or receiving nursing facility services, services in a medical institution at a level of care equivalent to nursing facility services, or services under the home and community based waiver program.

(4) For transfers made on or after July 1, 1988:

(a) A client is ineligible for the medical services specified in (3) for a period of time calculated in accordance with (4)(b)(i) and (ii) if, for the purpose of qualifying for medical assistance, the client has disposed of any resource, including his home, for less than fair market value within:

(i) 30 months immediately prior to institutionalization or at any time thereafter, in the case of a person who is receiving medical assistance on the date of institutionalization; or

(ii) 30 months immediately prior to the date of application for medical assistance or at any time after application, in the case of a person who is not receiving medical assistance on the date of institutionalization.

(b) The period of ineligibility will begin with the month in which the resources were transferred. The number of months in such period is equal to the lesser of:

(i) 30 months; or

(ii) the uncompensated value divided by Montana's statewide average private pay cost of nursing home services as determined by the department as of July 1 of the state fiscal year in which the transfer occurs.

(c) A person shall not be ineligible for medical assistance by reason of (4)(a) if:

(i) the property was transferred to a spouse or a blind or permanently and totally disabled child of the applicant or recipient;

(ii) the transferred property was the applicant's or recipient's home and was transferred to:

(A) the applicant's or recipient's spouse;

(B) a child of the applicant or recipient who is under age 21;

(C) a blind or permanently or totally disabled adult child of the applicant or recipient;

(D) a child of the applicant or recipient who resided in the home for at least two years prior to the client's institutionalization and who provided care which permitted the client to reside at home; or

(E) a sibling of the applicant or recipient who has equity interest in the home and resided in the home for at least one continuous year immediately preceding the client's institutionalization.

(iii) the property was transferred exclusively for a purpose other than to qualify for medical assistance; or

(iv) denial of eligibility would cause an undue hardship as defined in (1)(f).

(d) When a client, whether or not receiving medical assistance at the time of institutionalization, has disposed of any resource for less than fair market value within the periods of time described in (4)(a)(i) and (ii), it is presumed that the transfer was made for the purpose of qualifying for medical assistance, unless the client establishes by clear and convincing evidence that the transfer was exclusively for some other purpose.

(5) All property transfers made after December 19, 1989, by either the client or his spouse, will be evaluated as if the transfer was made by the client.

(6) For purposes of evaluating all transfers, regardless of date, the value of compensation received for transferred property is determined based upon the agreement and expectations of the parties at the time of the transfer. Compensation may be in the form of:

(a) cash, in the total amount paid or agreed to be paid in exchange for the resource, excluding interest;

(b) any valuable real or personal property which is valued according to its fair market value and which is exchanged for the property transferred;

(c) support and/or maintenance provided in accordance with a valid written contract entered into before the support and/or maintenance was rendered. The support and/or maintenance are valued at fair market value based upon the support and/or maintenance provided and the length of time for which the contract requires that it be provided;

(d) services provided in accordance with a valid written contract entered into before services were rendered. The services provided are valued at fair market value, considering the frequency and the duration of the services required by the contract;

(e) food valued at retail price; or

(f) shelter valued at fair market value.

(7) In all cases in which the department determines that an applicant or recipient has transferred resources to establish or maintain eligibility, regardless of the date of the transfer, the department must send a written notice to the individual, prior to a determination of eligibility or ineligibility, informing him that an uncompensated transfer of non-excluded resources has been identified, stating the value of the property transferred, and explaining the individual's right to rebut the presumption that the transfer was made to qualify for assistance.

(8) For purposes of evaluating all transfers, regardless of date, the presumption that property was transferred to establish medicaid eligibility shall apply unless the individual presents to the department, within 15 days of the department's mailing of notice, a rebuttal statement containing clear and convincing evidence that the property was transferred exclusively for some other reason. If the individual does not present a rebuttal statement as provided herein, the department shall deny or terminate eligibility.

(a) The individual's rebuttal statement must include, if applicable:

(i) the individual's reason for transferring the property;

(ii) the individual's attempts to transfer the property at fair market value;

(iii) the individual's representation and documentation that he did receive fair market value, if that is his belief and contention, or the individual's reasons for accepting less than fair market value for the property;

(iv) the individual's means of or plans for supporting himself after the transfer;

(v) the individual's relationship, if any, to the persons to whom the property was transferred; and

(vi) any relevant documentary evidence of the transfer or consideration received for the transfer including but not limited to legal documents, agreements, appraisals and correspondence regarding the transfer of property.

(b) The determination of whether a transfer covered by this section has occurred will be based upon consideration of all facts and circumstances. The presence of one or more of the following or other factors, while not necessarily conclusive, may indicate that the property was transferred exclusively for some purpose other than establishing eligibility;

(i) The occurrence or onset after transfer of an unexpected event or condition which necessitates application for medicaid benefits.

(ii) The occurrence after transfer of an unexpected loss of:

(A) other resources which would have precluded medicaid eligibility; or

(B) income which would have precluded medicaid eligibility.

(iii) If the property had been retained, the individual's total countable resources would have been below the general resource limit during each of the preceding 30 months.

(iv) The property transfer or restrictions upon the availability of the property to its owner were ordered by a court of law based upon an applicable statute, regulation, bona fide condition of settlement or other legal requirement and not at the request or suggestion of the client or the client's parent, child, guardian, attorney or other legal representative.

(v) The individual was the victim of fraud, misrepresentation or coercion and the transfer was based upon such fraud, misrepresentation or coercion, provided that the individual has taken any and all possible steps, including legal action, to recover such property or the equivalent thereof in damages.

(9) For purposes of evaluating all transfers, regardless of date, if the individual had some other purpose for transferring the property but establishing eligibility for public assistance was also a factor or foreseeable result of his decision to transfer, the presumption established in (4)(d) is not rebutted. (History: Sec. 53-2-201, 53-2-601 and 53-6-113, MCA; IMP, Sec. 53-2-601, 53-6-101, 53-6-113 and 53-6-143, MCA; NEW, 1981 MAR p. 1979, Eff. 1/1/82; AMD, 1987 MAR p. 710, Eff. 5/29/87; AMD, 1990 MAR p. 124, Eff. 1/12/90; AMD, 1991 MAR p. 262, Eff. 3/1/91; TRANS, from SRS, 2000 MAR p. 476; EMERG, AMD, 2003 MAR p. 652, Eff. 4/11/03.)

37.82.418 BONA FIDE EFFORT TO SELL NON-HOME REAL PROPERTY (REPEALED) (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, 53-6-141 and 53-6-142, MCA; NEW, 1989 MAR p. 882, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 476; EMERG, REP, 2003 MAR p. 652, Eff. 4/11/03.)

Rules 19 through 21 reserved

37.82.422 CONDITIONAL MEDICAL ASSISTANCE, DEFINITIONS

(1) Definitions for the purposes of conditional medical assistance include:

(a) "Non-liquid resource" is personal property which is not cash and which cannot be converted to cash within 20 workdays.

(b) "Liquid resource" is property which is cash or can be converted to cash within 20 workdays.

(c) "Net proceeds" is the current market value of the resource less sale costs and encumbrances. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1991 MAR p. 1045, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476.)

37.82.423 CONDITIONAL MEDICAL ASSISTANCE, ELIGIBILITY

(1) Medicaid applicants may qualify for assistance conditioned on the sale, at current market value, of excess non-liquid resources.

(2) To be eligible for conditional assistance an applicant must:

(a) be categorically eligible by reason of being:

(i) age 65 or older;

(ii) blind; or

(iii) disabled;

(b) have or apply for a social security number;

(c) meet the citizenship or alienage requirements of ARM 37.82.401;

(d) meet the residency requirements of ARM 37.82.402;

(e) have total countable resources which exceed the SSI-related resource standard of ARM 37.82.1110;

(f) not have countable liquid resources exceeding three times the appropriate federal supplemental security income monthly benefit payment standard at the time of application;

(g) make reasonable efforts to sell the resources as defined in (3) within the conditional assistance period specified in (4); and

(h) enter into a written agreement to use the net proceeds of the sale of the excess non-liquid resources to refund to the department conditional medical assistance payments paid on the applicant's behalf.

(3) "Reasonable efforts to sell" means:

(a) list the property for sale at market value or less with an agent; or

(b) begin advertising the property for sale at market value or less in at least one of the appropriate local media;

(c) place a "For Sale" sign on the property;

(d) begin conducting "open houses" or otherwise show the property to interested parties on a continuous basis; and

(e) attempt any other appropriate methods of sale.

(4) Conditional assistance may be provided to an eligible applicant for up to three months while attempting to dispose of excess personal property, and up to nine months while attempting to dispose of excess real property. An additional three months of conditional assistance may be provided to an applicant when the department determines that the sale of the resource has been prevented by circumstances beyond the applicant's control.

(5) The amount of conditional medical assistance to be refunded to the department is equal to the lesser of:

(a) balance of the net proceeds after an amount is deducted to raise the applicant's and spouse's, if any resources to the applicable resource limit; or

(b) total conditional medical assistance payments made on the applicant's and spouse's, if any, behalf. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1991 MAR p. 1045, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476; EMERG, AMD, 2003 MAR p. 652, Eff. 4/11/03.)

37.82.424 HEALTH PLAN PREMIUM PAYMENTS (1) "Group health plan" means any plan of an employer or any plan to which an employer contributes including a self-insured plan to provide health care, directly or otherwise, to the employer's employees, former employees, or the families of such employees or former employees.

(2) "Individual health plan" means any plan to provide health care to an individual and/or his family which is not a plan of the individuals's employer or to which the individual's employer contributes.

(3) "Cost effective" means the amount paid for premiums, co-insurance, deductibles, and other cost sharing obligations under an individual or group health plan plus the additional departmental administrative costs is likely to be less than the department would pay out for medicaid services for a medicaid recipient, determined on an actuarial basis.

(a) Cost effective criteria may include assessment of medical diagnoses and health risk assessment.

(4) Payment of individual or group health premiums is a medicaid benefit.

(5) The department of public health and human services may pay premiums of an individual or group health plan which provides benefits not covered by medicaid as long as it has determined that payment of the premiums will be cost effective.

(6) Coinsurance and deductibles will be paid for services covered by a health plan when these same services are provided by medicaid. Payment amounts cannot exceed the reimbursement schedule set by medicaid.

(a) Coinsurance and deductibles will not be paid for non-medicaid eligible persons who are covered by the health plan.

(b) Coinsurance and deductibles will not be paid for persons who are eligible for medicaid as COBRA continuation beneficiaries, as defined in ARM 46.12.3215.

(7) Payment of premiums may be made for a retroactive period up to three months if necessary to insure enrollment or continuation of enrollment.

(8) Payment of premiums may be in the form of direct payments to insurance companies or employers offering the health plan or direct reimbursement to the recipient or insured.

(9) Premiums for non-medicaid recipients may be paid only if it is a condition of the enrollee's eligibility in the health plan to enroll family members, and if premium payments are cost effective.

(a) Ineligible family members may reside in a separate household.

(10) Medicaid payment of health plan premiums may begin as of the medicaid eligibility effective date for:

(a) applicants who are already enrolled in a health plan; and

(b) applicants who have a waiting period before health plan coverage begins.

(i) Full medicaid coverage is available to applicants during the waiting period.

(11) Health plans are treated as a third party resource in accordance with ARM 37.85.407. (History: Sec. 53-2-201, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-103 and 53-6-131, MCA; NEW, 1991 MAR p. 1021, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476.)

Rules 25 through 29 reserved

37.82.430 COBRA CONTINUATION BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A person is a COBRA continuation beneficiary eligible for medicaid, if:

(a) the person meets the non-financial criteria in (2) of this rule;

(b) the person has countable resources which do not exceed twice the federal supplemental security income (SSI) resource limitation set forth at 42 USC 1382(a)(3)(A) and (B). The department hereby incorporates 42 USC 1382(a)(3)(A) and (B) as amended through April 1, 1991. Copies of 42 USC 1382(a) (3)(A) and (B), as amended through April 1, 1991, are available from the Department of Public Health and Human Services, Human and Community Services Division, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952;

(c) the person has countable income not in excess of 100% of the federal poverty income standard as defined by the executive office of management and budget (EOMB) and revised annually;

(d) the person is eligible for coverage under a group health plan provided by an employer with at least 75 employees pursuant to Title XXII of the Public Health Service Act, subsection 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act (ERISA) of 1974 due to a qualifying event;

(i) a COBRA continuation coverage qualifying event is:

(A) death of the covered employee;

(B) termination or reduction of hours of the covered employee's employment;

(C) divorce or legal separation of the covered employee from the employee's spouse;

(D) the covered employee becoming eligible for benefits under medicare; or

(E) a dependent child ceases to be a dependent child under the applicable plan requirements.

(e) it is cost effective to pay the health plan premiums according to the definition of cost effective in (2) of ARM 37.82.424.

(2) The non-financial criteria for determining eligibility of a COBRA continuation beneficiary are that the person:

(a) has or takes the necessary steps to obtain a social security number;

(b) meets the citizenship or alienage requirements of ARM 37.82.401; and

(c) meets the residency requirements of ARM 37.82.402.

(3) A person applying for and receiving medicaid as a COBRA continuation beneficiary is subject to the following provisions:

(a) ARM 37.82.201 concerning application requirements;

(b) ARM 37.82.204 concerning determinations of eligibility;

(c) ARM 37.82.205 concerning redetermination;

(d) ARM 37.82.407 concerning limitation on the financial responsibility of relatives; and

(e) ARM 37.82.415 concerning application for other benefits.

(4) Medical assistance for a person eligible for medicaid only as a COBRA continuation beneficiary shall be limited to payment of COBRA continuation premiums. The department will not pay co-insurance or deductibles under the group health plan or any other medicaid benefits for a COBRA continuation beneficiary. (History: Sec. 53-2-201, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-103 and 53-6-131, MCA; NEW, 1991 MAR p. 1021, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476.)

37.82.431 MEDICAID ESTATE RECOVERIES, WAIVER OF RECOVERY BASED UPON UNDUE HARDSHIP (1) The department shall waive, in whole or in part, its claim under 53-6-167, MCA, if the applicant demonstrates that recovery would result in an undue hardship to the applicant as provided in this rule.

(2) An applicant may request an undue hardship waiver of estate recovery by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, Quality Assurance Division, Third Party Liability, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953. Application forms may also be obtained from county human services or welfare offices, but must be filed with the quality assurance division office in Helena at the above address.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses and other matters relevant and necessary to determine whether an undue hardship would result from recovery.

(3) The persons entitled to apply for an undue hardship waiver as provided in this rule are:

(a) a person who has succeeded or would succeed to part or all of the decedent's assets but for recovery by the department, including a person who has received or would have received a beneficial interest in the assets but not legal title; or

(b) a person who was, for a substantial period of time during the decedent's lifetime and after the decedent's death remains, dependent upon the decedent's assets for food, shelter or clothing.

(4) Department recovery will result in an undue hardship to the applicant if:

(a) The estate assets or property received by survival or distribution are part of a business, including a working farm or ranch, upon which the applicant was dependent for applicant's livelihood, during the decedent's lifetime recovery by the department would deprive the applicant of their sole means of livelihood, and the applicant has no other means of satisfying the department's claim;

(b) The applicant is an aged (age 65 or over), blind or disabled relative of the decedent who for one year or more before the decedent's death had been continuously and lawfully living in a residence owned by the decedent and continues to reside there, and who would have significant difficulty establishing an alternative living arrangement, obtaining financing (such as a home equity loan) to repay the department or arranging other means to repay the department;

(c) The applicant is a relative of the decedent who for one year or more before the decedent's death had been continuously and lawfully living in a residence owned by the decedent and continues to reside there, and who would have no means of providing or obtaining alternative shelter and there is no person legally responsible or assets otherwise available to provide the person shelter;

(d) Without recovery by the department, the applicant would receive or be permitted to retain property that the applicant transferred to the decedent for no consideration, as determined by clear and convincing evidence including appropriate title documents, agreements and other documentation; or

(e) The property that applicant would receive or be permitted to retain without recovery by the department is needed by the applicant to acquire necessities of life, such as food, shelter, clothing or medical care and there are no other assets or means available to the applicant to satisfy in full or in part the department's claim.

(5) An undue hardship does not exist if:

(a) the decedent or applicant created the hardship by using estate planning, gifting or other methods to divert or shelter assets to avoid estate recovery; or

(b) The circumstances indicate that the hardship was created for purposes of avoiding or defeating recovery.

(6) The department may limit an undue hardship waiver to a partial or temporary waiver of recovery and/or may condition a waiver upon the applicant's agreement and provision of security for repayment in appropriate cases if the limited waiver would address reasonably the applicant's hardship.

(7) To the extent that there currently is, or later comes into existence, a conflict between the provisions of this rule and standards promulgated by the secretary of the U.S. department of health and human services, the federal standards shall control.

(8) The department shall provide the applicant written notice of its determination on an application for an undue hardship waiver of estate recovery.

(9) An applicant aggrieved by an adverse determination on an application for an undue hardship waiver of estate recovery may assert a claim of entitlement to an undue hardship waiver as provided in 53-6-167(7)(c), MCA rather than through an administrative review, fair hearing or contested case hearing under the Montana Administrative Procedure Act or the department's rules. (History: Sec. 53-6-167 and 53-6-189, MCA; IMP, Sec. 53-6-167, MCA; NEW, 1995 MAR p. 2837, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 476.)

Rules 32 through 34 reserved

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37.82.435 MEDICAID REAL PROPERTY LIEN, NOTICE AND RIGHT TO HEARING (1) At least 90 days prior to filing a lien under 53-6-171, MCA upon real property of a medicaid applicant or recipient, the department must provide the applicant or recipient notice of its determination that applicant or recipient is permanently institutionalized and that none of the exceptions provided by 53-6-171, MCA or federal law apply. The notice must inform the applicant or recipient of the exceptions that would prevent imposition of a lien and of the right to a fair hearing as provided in (2).

(2) The applicant or recipient upon whose property the department proposes to impose a lien under 53-6-171, MCA is entitled to a fair hearing according to the provisions of ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.318, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. The applicant or recipient must request the hearing within 90 days of receipt of the notice required under (1).

(a) The hearing is limited to issues regarding imposition of the lien and may not address issues relating to recovery on the lien, undue hardship, spousal exemption or similar issues.

(3) If a hearing is requested, the department may not file the lien until permitted to do so by order of the hearing officer or a court of law, which may be granted after a determination on the merits or before a determination on the merits upon a demonstration by the department that the lien is necessary to prevent the applicant, recipient or other person from disposing of the property to avoid the lien. (History: Sec. 2-4-201 and 53-6-189, MCA; IMP, Sec. 2-4-201, 53-6-171 and 53-6-172, MCA; NEW, 1995 MAR p. 2837, Eff. 12/22/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.82.436 MEDICAID REAL PROPERTY LIEN, WAIVER OF LIEN RECOVERY BASED UPON UNDUE HARDSHIP (1) The department shall waive, in whole or in part, its recovery upon a lien under 53-6-171 through 53-6-188, MCA, if the applicant demonstrates that recovery would result in an undue hardship to the applicant.

(a) A waiver may be granted under this rule only to forego or prevent recovery under a lien previously imposed under 53-6-171, MCA. A waiver may not be granted under this rule to forego or prevent imposition of a lien under 53-6-171, MCA.

(2) An applicant may request an undue hardship waiver of lien recovery by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, Quality Assurance Division, Third Party Liability, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953. Application forms may also be obtained from county human services or welfare offices, but must be filed with the quality assurance division office in Helena at the above address.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses and other matters relevant and necessary to determine whether an undue hardship would result from recovery.

(3) The persons entitled to apply for an undue hardship waiver as provided in this rule are:

(a) a person who has succeeded or would succeed to part or all of the recipient's interest in the liened property but for recovery by the department, including a person who has received or would have received a beneficial interest in the liened property but not legal title; or

(b) a person who is dependent upon the liened property for shelter or if the recipient is deceased, was, for a substantial period of time during the recipient's lifetime and after the decedent's death remains dependent upon the liened property for shelter.

(4) Department recovery will result in an undue hardship to the applicant if:

(a) The liened property is part of a business, including a working farm or ranch, upon which the applicant was dependent for applicant's livelihood during the recipient's lifetime, lien recovery by the department would deprive the applicant of their sole means of livelihood, and the applicant has no other means of satisfying the department's claim;

(b) The applicant is an aged (age 65 or older), blind or disabled relative of the recipient who for one year or more before the recipient's death had been continuously and lawfully living in the liened property and continues to reside there, and who would have significant difficulty establishing an alternative living arrangement, obtaining financing (such as a home equity loan) to repay the department or arranging other means to repay the department;

(c) The applicant is a relative of the recipient who for one year or more before the recipient's death had been continuously and lawfully living in the liened property and continues to reside there, and who would have no means of providing or obtaining alternative shelter and there is no person legally responsible or assets otherwise available to provide the person shelter;

(d) Without lien recovery by the department, the applicant would receive or be permitted to retain liened property that the applicant transferred to the recipient for no consideration, as demonstrated by clear and convincing evidence, including appropriate title documents, agreements and other documentation; or

(e) The liened property is needed by the applicant for shelter and there are no other assets or means available to the applicant to satisfy in full or in part the department's claim.

(5) An undue hardship does not exist if:

(a) the recipient or applicant created the hardship by using estate planning, gifting or other methods to divert or shelter assets to avoid estate recovery; or

(b) the circumstances indicate that the hardship was created for purposes of avoiding or defeating recovery.

(6) The department may limit an undue hardship waiver to a partial or temporary waiver of lien recovery and/or may condition a waiver upon the applicant's agreement and provision of security for repayment in appropriate cases if the limited waiver would address reasonably the applicant's hardship.

(7) To the extent that there currently is, or later comes into existence, a conflict between the provisions of this rule and standards promulgated by the secretary of the U.S. department of health and human services, the federal standards shall control.

(8) The department shall provide the applicant written notice of its determination on an application for an undue hardship waiver of lien recovery.

(9) An applicant aggrieved by an adverse determination on an application for an undue hardship waiver of lien recovery may assert a claim of entitlement to an undue hardship waiver as provided in 53-6-180(1)(c), MCA, rather than through an administrative review, fair hearing or contested case hearing under the Montana Administrative Procedure Act or the department's rules. (History: Sec. 53-6-180 and 53-6-189, MCA; IMP, Sec. 53-6-180, MCA; NEW, 1995 MAR p. 2837, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 476.)

37.82.437 MEDICAID REAL PROPERTY LIEN, SPOUSE'S LIMITED RECOVERY EXEMPTION (1) The department shall provide to the recipient's surviving spouse an exemption from recovery on a lien under 53-6-171, MCA to the extent and under the conditions specified in 53-6-182, MCA, according to the procedures and requirements specified in this rule.

(a) An exemption may be granted under this rule only to forego, prevent or reduce a recovery under a lien previously imposed under 53-6-171, MCA. An exemption may not be granted under this rule to forego or prevent imposition of a lien under 53-6-171, MCA.

(2) A recipient's spouse may request the exemption by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, Quality Assurance Division, Lien Recoveries, 2401 Colonial Drive, Helena, P.O. Box 202953, Helena MT 59620-2953. Application forms may also be obtained from county human services or welfare offices, but must be filed with the quality assurance division office in Helena at the above address.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses, fair market value of assets, and other matters relevant and necessary to determine entitlement to and the amount of any exemption under this rule.

(3) The department must provide the applicant notice of its determination on an application for the spousal exemption. The notice must inform the applicant of the right to a fair hearing as provided in (4).

(4) An applicant aggrieved by the department's determination on an application for a spousal exemption under this rule is entitled to a fair hearing according to the provisions of ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.318, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. The applicant or recipient must request the hearing within 30 days of receipt of the notice required under (3).

(5) If a hearing is requested, the department may, subject to order of the hearing officer or a court having jurisdiction of the matter, take action to preserve the security of the lien but may not take further action to recover upon the lien until permitted to do so by order of the hearing officer or a court of law, which may be granted after a determination on the merits or before a determination on the merits upon a demonstration by the department that the lien is necessary to prevent the applicant or another party from disposing of the property to avoid the lien. (History: Sec. 2-4-201, 53-6-182 and 53-6-189, MCA; IMP, Sec. 2-4-201 and 53-6-182, MCA; NEW, 1995 MAR p. 2837, Eff. 12/22/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.82.438 MEDICAID REAL PROPERTY LIEN, RELEASE OF LIEN AFTER RECIPIENT'S RETURN HOME (1) If a recipient upon whose real property the department has imposed a lien under 53-6-171, MCA has been discharged from the facility and has returned home, the department shall upon written request file a release of the lien in the clerk and recorder's office.

(2) The written request must contain the name and social security number of the recipient and must be accompanied by a copy of the legal description of the property subject to the lien.

(3) The department may require reasonable documentation or verification that the recipient has been discharged from the facility and returned home. (History: Sec. 53-6-189, MCA; IMP, Sec. 53-6-174, MCA; NEW, 1995 MAR p. 2837, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 476.)

Subchapters 5 and 6 reserved

Subchapter 7

Eligibility Requirements for the Non-Institutionalized Categorically Needy: AFDC-Related Families and Children

37.82.701 GROUPS COVERED, NON-INSTITUTIONALIZED FAMILIES AND CHILDREN (1) Medicaid will be provided to:

(a) individuals under age 19 who currently reside in Montana and are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, whether or not such assistance originated in Montana. Eligibility requirements for Title IV-E foster care and adoption assistance are found in ARM 37.50.101, 37.50.105, 37.50.106 and 45 CFR part 233.

(b) individuals who have been receiving assistance in the non-medically needy family medicaid program and whose assistance is terminated because of earned income. These individuals may continue to receive medicaid for any or all of the 12 calendar months immediately following the month in which non-medically needy family medicaid is last received, providing:

(i) in cases where assistance was terminated due to earned income, a member of the assistance unit continues to be employed during the 12 months; however, eligibility may continue even though no member of the assistance unit is employed if there was a good cause as defined in ARM 37.78.508 for the termination or loss of employment;

(ii) they received non-medically needy family medicaid for three of the six months immediately prior to the month they became ineligible for non-medically needy family medicaid coverage; and

(iii) there continues to be an eligible child in the assistance unit. This coverage group is known as the "extended medicaid group".

(c) individuals under age 19 who live with a specified caretaker relative as defined in ARM 37.78.103 and who meet all other eligibility requirements;

(d) a pregnant woman whose pregnancy has been verified and whose family income and resources meet the requirements listed in ARM 37.82.1106, 37.82.1107 and 37.82.1110. This coverage group is known as the "qualified pregnant woman group";

(i) The unborn child shall be considered an additional member of the assistance unit for purposes of determining eligibility.

(e) a pregnant woman whose pregnancy has been verified, whose family income does not exceed 133% of the federal poverty guidelines and whose countable resources do not exceed $3,000. This coverage group is known as the "poverty level pregnant woman group";

(i) The unborn child shall be considered an additional member of the assistance unit for purposes of determining eligibility.

(ii) newborn children are continuously eligible through the month of their first birthday, provided they continue to reside with their mother in Montana and she would continue to be eligible for assistance if she were still pregnant. This coverage group is known as the "automatic newborn assistance group";

(f) a pregnant woman during a period of presumptive eligibility;

(i) Presumptive eligibility is established by submission of an application by the applicant on the form specified by the department, to a qualified presumptive eligibility provider, verification of pregnancy and a determination by the qualified presumptive eligibility provider that applicant's household income and resources do not exceed the income and resource standards specified in (1)(e).

(A) A qualified presumptive eligibility provider is an entity which meets the requirements specified in section 3570 of the state medicaid manual, published by the centers for medicare and medicaid services (CMS) of the U.S. department of health and human services and who is enrolled with the department as a qualified presumptive eligibility provider under the presumptive eligibility program. Section 3570 of the state medicaid manual is hereby adopted and incorporated herein by this reference. A copy of the manual section may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(B) Presumptive eligibility determinations shall be effective through the earlier of the date the department makes a determination of eligibility or ineligibility based upon a medicaid application, or the last day of the month following the month of the presumptive eligibility determination, if no medicaid application is filed within such period. An individual is limited to one presumptive eligibility period per pregnancy.

(C) The applicant or recipient shall be entitled to a fair hearing with respect to a determination by the department based upon a medicaid application.

(ii) During a period of presumptive eligibility, a pregnant woman is limited to ambulatory prenatal care services covered under the Montana medicaid program. Such services may be provided by any medicaid provider eligible to receive medicaid reimbursement for such services under applicable law and regulations.

(g) a pregnant woman who becomes ineligible for medicaid due solely to increased income and whose countable resources do not exceed $3,000 and whose pregnancy is disclosed to the department and verified prior to the effective date of medicaid closure. This coverage group is known as the "continuous pregnant woman group";

(i) Eligibility shall be continuous without lapse in medicaid eligibility from the prior medicaid eligibility and shall terminate on the last day of the month in which the 60th postpartum day occurs.

(h) a child born on or after October 1, 1983, who has attained age six but has not yet reached age 19, whose family income does not exceed 100% of the federal poverty guidelines and whose countable resources do not exceed $3,000. This coverage group is known as the "poverty six child group";

(i) a child through the month of the sixth birthday whose family income does not exceed 133% of the federal poverty guidelines and whose countable resources do not exceed $3,000; this group is known as the "poverty level child group";

(j) individuals under the age of 21 who are receiving foster care or subsidized adoption payments through child welfare services;

(i) These individuals must have full or partial financial responsibility assumed by public agencies and must have been placed in foster homes, private institutions or private homes by a non-profit agency.

(k) a child of a minor custodial parent when the custodial parent is living in the child's grandparent's home and the grandparent's income is the sole reason rendering the child ineligible for non-medically needy family medicaid;

(l) needy caretaker relatives as defined in ARM 37.78.103 who have in their care an individual under age 19 who is eligible for medicaid, and whose countable income does not exceed the state's family medicaid standards as defined in the family medicaid manual, section 002;

(m) a child through the month of the child's 19th birthday, who lives in a household whose income and resources do not exceed the medically needy income and resource standards specified in ARM 37.82.1106, 37.82.1107 and 37.82.1110, regardless of whether the child lives with a parent or specified caretaker relative as defined in ARM 37.82.103. This coverage group is known as the "Ribicoff child group";

(n) women, under the age of 65 who have been screened through the Montana breast and cervical health program who:

(i) have been diagnosed with cancer or precancer of the breast or cervix;

(ii) do not have creditable coverage to pay for their cancer/precancer treatment;

(iii) have countable income that does not exceed 200% of the federal poverty level; and

(iv) are not eligible for any other medicaid coverage group. This coverage group is known as "breast and cervical cancer treatment"; and

(o) families who, due to receipt of new or increased child or spousal support, lose eligibility for non-medically needy family medicaid. To be eligible the family must:

(i) receive new or increased child or spousal support in an amount great enough to cause their non-medically needy family medicaid eligibility to end; and

(ii) have received non-medically needy family medicaid in Montana for three of six months prior to the closure of non-medically needy family medicaid. The coverage will continue for four consecutive months. This program is know as the "extended child/spousal support group".

(2) Medicaid will continue until the last day of the month in which the 60th postpartum day falls for pregnant women as long as the pregnant woman was eligible for and receiving medicaid on the date pregnancy ends.

(3) Medicaid will continue for one year for newborn children providing:

(a) the mother was eligible for and receiving medicaid at the time of the newborn's birth;

(b) the mother of the newborn remains eligible;

(c) the child remains in the same household as the mother; and

(d) the mother remains a Montana resident.

(4) Medicaid may be provided for up to three months prior to the date of application for individuals listed in (1)(a), (1)(c), (1)(d), (1)(g), (1)(h), (1)(i), (1)(j), (1)(k), (1)(l) and (1)(m) if all financial and non-financial eligibility criteria are met as of the date medical services were received in each of those months. (History: Sec. 53-4-212 and 53-6-113, MCA; IMP, Sec. 53-4-231, 53-6-101, 53-6-131 and 53-6-134, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1984 MAR p. 1478, Eff. 10/12/84; AMD, 1985 MAR p. 500, Eff. 5/17/85; AMD, 1986 MAR p. 1604, Eff. 9/26/86; AMD, 1987 MAR p. 1655, Eff. 9/25/87; AMD, 1989 MAR p. 883, Eff. 7/1/89; AMD, 1990 MAR p. 541, Eff. 4/1/90; AMD, 1990 MAR p. 542, Eff. 4/1/90; AMD, 1991 MAR p. 516, Eff. 4/26/91; AMD, 1991 MAR p. 1046, Eff. 6/28/91; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1988 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2002 MAR p. 1773, Eff. 6/28/02.)

37.82.702 NON-FINANCIAL REQUIREMENTS, NON-INSTITUTIONALIZED FAIM FINANCIAL ASSISTANCE RELATED FAMILIES AND CHILDREN (1) Individuals eligible for FAIM financial assistance are presumed to have met the non-financial requirements of the medicaid program.

(2) For individuals under 19 who are not eligible for foster care or adoption assistance under Title IV-E or do not qualify as dependent children, the nonfinancial requirements for medicaid under this subchapter are as provided in ARM 37.82.701(3). (History: Sec. 53-4-211, 53-4-212, 53-4-231 and 53-6-113, MCA; IMP, Sec. 53-4-211, 53-4-212 and 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1991 MAR p. 1734, Eff. 9/13/91; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.703 FINANCIAL REQUIREMENTS, NON-INSTITUTIONALIZED FAIM FINANCIAL ASSISTANCE RELATED FAMILIES AND CHILDREN

(1) Individuals eligible for FAIM financial assistance are presumed to have met all the financial requirements for medicaid eligibility.

(2) Notwithstanding the above and in accordance with ARM 37.82.701(1)(d), for purposes of this coverage group:

(a) the increase in OASDI benefits on July 1, 1972 will be excluded from unearned income; and

(b) ineligibility for FAIM financial assistance on the basis of the gross monthly income test found in ARM 46.18.122 will not preclude continued medicaid coverage under ARM 37.82.701(1)(c).

(3) For individuals under 19 who are not eligible for foster care or adoption assistance under Title IV-E or do not qualify as dependent children, the FAIM financial requirements which are set forth in ARM 46.18.118 through 46.18.122 will be used to determine whether:

(a) the individual in his placement is eligible with respect to resources;

(b) the individual in his placement is eligible with respect to gross and net income and with respect to the applicable benefit standards.

(c) In applying the above:

(i) because the individual is not living with his parent, parental income will be considered only when actually contributed; and

(ii) applicable standards are the child only standards.

(4) In determining medicaid eligibility, an unborn child is considered a family member. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-4-231 and 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1987 MAR p. 1655, Eff. 9/25/87; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.704 THREE MONTH RETROACTIVE COVERAGE, NON-INSTITUTIONALIZED FAIM FINANCIAL ASSISTANCE RELATED FAMILIES AND CHILDREN (1) Three month retroactive coverage will be provided to individuals determined eligible for medicaid under this subchapter if:

(a) they received medical services during any of the 3 months prior to application;

(b) they are determined eligible for medicaid on the 1st day of the month in the month or months medical services were received.

(c) Eligibility in the retroactive period will be determined in accordance with this subchapter, except that eligibility with respect to income will be determined using actual income received in the month or months of service.

(2) Under (1), medicaid will pay only unpaid bills for services:

(a) incurred in the retroactive period;

(b) provided for in chapters 82, 83, 85, 86 and 88; and

(c) for which no third party payment is available. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

Subchapter 8 reserved

Subchapter 9

Eligibility Requirements for the Non-Institutionalized Categorically Needy: SSI-Related Individuals and Couples

37.82.901 GROUPS COVERED, NON-INSTITUTIONALIZED SSI-RELATED INDIVIDUALS AND COUPLES (1) Medicaid will be provided to:

(a) Aged, blind or disabled individuals or couples receiving SSI, including:

(i) those receiving SSI pending final determination of blindness or disability;

(ii) those receiving SSI under an agreement with the social security administration to dispose of resources that exceed the SSI dollar limits on resources; and

(iii) those deemed to be receiving SSI under the special SSI eligibility status granted by the social security administration to certain severely impaired individuals who work.

(b) Aged, blind or disabled individuals or couples receiving mandatory state supplements.

(c) Aged, blind or disabled individuals or couples receiving only a state supplementary payment (but no SSI payment) under the optional state supplementary program established in ARM 37.43.101 through 37.43.104.

(2) Medicaid will also be provided to aged, blind or disabled individuals or couples who are not receiving SSI. This coverage is limited to:

(a) Individuals who would be eligible for SSI had they applied.

(b) Individuals who, in August 1972, were eligible for OASDI and who were also receiving OAA, AB, APTD, or AABD or would have been receiving such cash assistance had they applied, providing:

(i) they meet all current SSI non-financial requirements identified as applicable to medicaid eligibility in ARM 37.82.902;

(ii) they meet all current SSI resource limitations identified as applicable to medicaid eligibility in ARM 37.82.903; and

(iii) they would currently be eligible for an SSI payment if the increase in OASDI benefits on July 1, 1972 had not raised individual or couple income over the SSI income standards identified as applicable to medicaid eligibility in ARM 37.82.903.

(c) Individuals who are receiving OASDI and were receiving SSI but became ineligible due solely to a cost-of-living increase in OASDI paid under section 215(i) of the Social Security Act after April 1977, providing they would still be eligible for SSI if such increases were excluded from income.

(d) Individuals who would currently be eligible for an SSI payment if the January 1, 1984, increase in social security retirement benefits for disabled widows or widowers had not raised the individual income over the SSI income standards identified as applicable to medicaid eligibility in ARM 37.82.903.

(e) Widow(er)s who no longer receive SSI benefits or state supplemental payments as a result of becoming entitled to and receiving Title II benefits. Coverage is limited to individuals who are:

(i) between the ages of 60 and 65;

(ii) eligible for and receiving early widow(er)'s benefits from social security;

(iii) ineligible for SSI benefits or state supplemental payments due to receipt of social security early widow(er)'s benefits; and

(iv) not entitled to medicare Part A (hospital insurance).

(3) Medicaid will also be provided to aged, blind or disabled individuals or couples who are not receiving a state supplementary payment under the optional state supplementary program. This coverage is limited to:

(a) Individuals who, in August 1972, were eligible for OASDI and who were also receiving OAA, AB, APTD, or AABD or would have been receiving such cash assistance had they applied, providing:

(i) they meet all current optional state supplementary program non-financial requirements identified as applicable to medicaid eligibility in ARM 37.82.902;

(ii) they meet all current optional state supplementary program resource limitations identified as applicable to medicaid eligibility in ARM 37.82.903; and

(iii) they would currently be eligible for a state supplementary payment if the increase in OASDI benefits on July 1, 1972 had not raised individual or couple income over the optional state supplementary program income standards identified as applicable to medicaid eligibility in ARM 37.82.903.

(b) Individuals who are receiving OASDI and were receiving a state supplementary payment under the optional state supplementary program but became ineligible due solely to a cost-of-living increase in OASDI paid under section 215(i) of the Social Security Act after April 1977, providing they would still be eligible for a state supplementary payment if such increases were excluded from income.

(4) Finally, medicaid will be provided to individuals who were eligible for medicaid in December 1973. This coverage is limited to:

(a) Individuals who in December 1973 were eligible for medicaid as an essential spouse of a recipient of OAA, AB, APTD, or AABD, providing:

(i) the spouse has continued to live with and be essential to the well being of the former recipient of OAA, AB, APTD, or AABD;

(ii) the former recipient of OAA, AB, APTD, or AABD continues to meet the December 1973 eligibility requirements; and

(iii) the spouse continues to meet the December 1973 requirements for having his needs included in computing the cash payment available in December 1973.

(b) Individuals who meet all current SSI non-financial and financial requirements identified as applicable to medicaid eligibility in ARM 37.82.902 and 37.82.903 except the blindness or disability criteria, providing:

(i) they were eligible for medicaid in December 1973 as blind or disabled; and

(ii) for each consecutive month after December 1973, they continue to meet not only the December 1973 blindness or disability criteria, but also all other December 1973 eligibility criteria.

(5) Medicaid will be provided to a disabled widow, disabled widower or disabled surviving divorced spouse who loses supplemental security income benefits or state supplemental payments and therefore medicaid eligibility because the person is determined to be eligible for social security, if the person meets the following criteria:

(a) The person was eligible for supplemental security income or state supplemental payments the month before the person began receiving social security benefits;

(b) The person would continue receiving supplemental security income or state supplemental payments if the person's social security benefit was not counted as income; and

(c) The person is not entitled to enroll in the hospital insurance plan (Part A) of medicare. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1987 MAR p. 208, Eff. 2/27/87; AMD, 1988 MAR p. 2231, Eff. 10/14/88; AMD, 1991 MAR p. 1049, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476.)

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37.82.902 NON-FINANCIAL REQUIREMENTS, NON-INSTITUTIONALIZED SSI-RELATED INDIVIDUALS AND COUPLES (1) Aged, blind or disabled individuals or couples receiving SSI, mandatory state supplements, or only a state supplementary payment under the optional state supplementary program are presumed to have met the non-financial requirements for medicaid eligibility.

(2) For individuals and couples under the heading aged, blind or disabled individuals or couples who are not receiving SSI, the SSI non-financial requirements which are set forth in 20 CFR Part 416, Subparts H and I, will be used to determine whether an individual is aged, blind or disabled. 20 CFR Part 416, Subpart H, contains the SSI criteria for determining age, and 20 CFR Part 416, Subpart I, contains the SSI criteria for determining blindness and disability. The department hereby adopts and incorporates by reference 20 CFR Part 416, Subparts H and I. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(3) For individuals and couples under the heading aged, blind or disabled individuals or couples who are not receiving a state supplementary payment under the optional state supplementary program, the optional state supplementary program non-financial requirements set forth in ARM 37.43.101 through 37.43.104 will be used to determine whether an individual is aged, blind or disabled and is certified as requiring the services covered by the state supplementary payment.

(4) For individuals under the heading individuals who were eligible for medicaid in December 1973, the December 1973 OAA, AB, APTD, or AABD non-financial requirement will be used to determine whether an individual continues to be a medicaid eligible essential spouse, as provided in ARM 37.82.901(4)(a), or may be considered blind or disabled in spite of SSI criteria, as provided in ARM 37.82.902(4)(b). A copy of the December 1973 OAA, AB, APTD, and AABD non-financial requirements may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

37.82.903 FINANCIAL REQUIREMENTS, NON-INSTITUTIONALIZED SSI-RELATED INDIVIDUALS AND COUPLES (1) Aged, blind or disabled individuals or couples receiving SSI, mandatory state supplements, or only a state supplementary payment under the optional state supplementary program are presumed to have met the financial requirements for medicaid eligibility.

(2) For individuals and couples under the heading aged, blind or disabled individuals or couples who are not receiving SSI, the SSI financial requirements which are set forth in 20 CFR Part 416, Subparts J, K and L, will be used to determine whether an individual or couple is eligible with respect to resources and with respect to income. 20 CFR Part 416, Subpart J, contains the SSI criteria for evaluating family relationships; 20 CFR Part 416, Subpart K, for evaluating income, including the income of financially responsible relatives; and 20 CFR Part 416, Subpart L, for evaluating resources, including the resources of financially responsible relatives. The department hereby adopts and incorporates by reference 20 CFR Part 416, Subparts J, K and L. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(a) Notwithstanding the above and in accordance with ARM 37.82.901(2)(b), (c), (d) and (e) for purposes of this coverage group:

(i) the increase in OASDI benefits on July 1, 1972, will be excluded from unearned income;

(ii) any cost-of-living increases in OASDI paid under section 215(i) of the Social Security Act after April 1977 will be excluded from unearned income; and

(iii) the January 1, 1984, increase in social security disabled widow's and widower's benefits caused by an elimination factor for individuals who became entitled to said benefits before age 60 will be excluded from unearned income; and

(iv) Title II early widow(er)'s benefits for individuals who meet eligibility criteria at ARM 37.82.901(2)(e) will be excluded from unearned income.

(b) In addition, aged, blind or disabled individuals who would be institutionalized solely because of the income and resources requirements relating to financially responsible relatives will be exempt from those requirements and such individuals will have their eligibility determined on the basis of their own income and resources if the department approves such an exemption. The administrative mechanism for approval of this exemption shall consist of:

(i) The department shall review individual cases.

(ii) The department will accept applications for exemption only from department long term care specialists, and developmental disabilities division area office staff, who must recommend that the income and resources requirements relating to financially responsible relatives not be applied in the particular case.

(iii) The application must justify the exemption by showing that:

(A) The economic burden on the financially responsible relative for the care of the individual is the sole reason that institutionalization of the individual is being pursued. The burden on the financially responsible relative of personally providing care to the individual is not a factor.

(B) Enabling the applicant to be eligible for medicaid on the basis of his own income and resources will result in an individual plan of care for home and community-based services which is feasible and cost-effective as provided in ARM 46.12.1411.

(c) For a disabled widow, disabled widower or disabled surviving divorced spouse receiving social security benefits who is eligible for medicaid as provided in ARM 37.82.901 the social security benefits are excluded from countable income.

(3) For individuals and couples under the heading aged, blind or disabled individuals or couples who are not receiving a state supplementary payment under the optional state supplementary program, the optional state supplementary program financial requirements set forth in ARM 37.43.101 through 37.43.104 will be used to determine whether an individual or couple is eligible with respect to resources and with respect to income.

(a) Notwithstanding the above and in accordance with ARM 37.82.901(3)(a) and (b), for purposes of this coverage group:

(i) the increase in OASDI benefits on July 1, 1972 will be excluded from unearned income; and

(ii) any cost-of-living increases in OASDI paid under section 215(i) of the Social Security Act after April 1977 will be excluded from unearned income.

(4) For individuals under the heading individuals who were eligible for medicaid in December 1973, the December 1973 OAA, AB, APTD, or AABD financial requirements will be used to determine whether the individual continues to be eligible with respect to December 1973 medicaid financial criteria. A copy of the December 1973 OAA, AB, APTD, and AABD financial requirements may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(a) When individuals under this heading must also meet current medicaid financial requirements, as provided in ARM 37.82.901(4)(b), the SSI financial requirements identified in (2) above apply. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1983 MAR p. 1079, Eff. 8/15/83; AMD, 1987 MAR p. 208, Eff. 2/27/87; AMD, 1988 MAR p. 2231, Eff. 10/14/88; AMD, 1991 MAR p. 1049, Eff. 6/28/91; TRANS, from SRS, 2000 MAR p. 476.)

37.82.904 THREE MONTH RETROACTIVE COVERAGE, NON-INSTITUTIONALIZED SSI-RELATED INDIVIDUALS AND COUPLES

(1) Three month retroactive coverage will be provided to individuals determined eligible for medicaid under this subchapter if:

(a) they received medical services during any of the three months prior to application;

(b) they are determined eligible for medicaid in the month or months medical services were received.

(c) Eligibility in the retroactive period will be determined in accordance with this subchapter, except that eligibility with respect to income will be determined using actual income received in the month or months of service.

(2) Under (1), medicaid will pay only unpaid bills for service:

(a) incurred in the retroactive period;

(b) provided for in this chapter; and

(c) for which no third party payment is available. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Subchapter 10 reserved

Subchapter 11

Eligibility Requirements for the Non-Institutionalized Medically Needy

37.82.1101 INDIVIDUALS COVERED, NON-INSTITUTIONALIZED MEDICALLY NEEDY (1) Medicaid under this subchapter will be provided to the following individuals who would be receiving FAIM financial assistance if their income had not exceeded the income standards found in ARM 46.18.122 provided they are also eligible under ARM 37.82.1102, 37.82.1106, 37.82.1107 and 37.82.1110:

(a) pregnant women whose pregnancy has been verified;

(b) individuals who are under the age of 18 or are age 18 and a full-time student in a secondary school and can reasonably be expected to obtain a secondary school diploma or its equivalent in or before the month of their 19th birthday;

(c) a child born on or after October 1, 1983, through the month of their 19th birthday whose family income and resources meet the requirements listed in ARM 37.82.1106 and 46.18.118;

(d) individuals under age 19 who are ineligible for medicaid under ARM 37.82.701; and

(e) individuals in a FAIM financial assistance lump sum period of ineligibility.

(2) This group does not include individuals whose cash assistance is terminated solely because of increased income from employment and who, under ARM 37.82.701, are receiving continued medicaid coverage. However, this group may be eligible when the medicaid coverage terminates.

(3) This group does not include coverage for the caretaker relative, as defined in ARM 46.10.403.

(4) Medicaid under this subchapter will also be provided to the following groups of non-institutionalized SSI-related individuals and couples:

(a) Individuals who would be receiving SSI if their income had not exceeded the current SSI income standards.

(i) This group does not include aged, blind or disabled individuals or couples receiving mandatory state supplements or only a state supplementary payment (but no SSI payment) under the optional state supplementary program established in ARM 37.43.101 through 37.43.104. Under subchapter 9, these individuals are eligible for medicaid on the basis of income standards higher than the current SSI income standards. However, this group does include such individuals when increased income causes ineligibility for such supplementary payments. At this juncture, for the purposes of medicaid under the present subchapter, any income used to meet needs previously met by the supplementary payment is not excluded from income.

(ii) This group does not include individuals who are currently ineligible for SSI or only a state supplementary payment under the optional state supplementary program because the increase in OASDI benefits they received on July 1, 1972, raised individual or couple income over the current SSI or optional state supplementary program income standards. These individuals, under ARM 37.82.901(2)(b) and (3)(a) and 37.82.903(2) and (3), have their July 1, 1972, increase in OASDI benefits excluded from unearned income and are determined eligible for medicaid under subchapter 9. However, this group does include such individuals when, after excluding the July 1, 1972 increase in OASDI benefits, other income causes ineligibility for medicaid under subchapter 9. At this juncture, for the purposes of medicaid under the present subchapter, the July 1, 1972, increase in OASDI benefits is no longer excluded from but is counted as unearned income.

(iii) This group does not include individuals who are currently ineligible for SSI or only a state supplementary payment under the optional state supplementary program solely due to a cost-of-living increase in OASDI paid under section 215 (i) of the Social Security Act after April, 1977. These individuals, under ARM 37.82.901(2)(c) and (3)(b) and 37.82.903(2) and (3), have such increases excluded from unearned income and are determined eligible for medicaid under subchapter 9. However, this group does include such individuals when, after excluding such increases, other income causes ineligibility for medicaid under Chapter 85, subchapter 20. At this juncture, for the purposes of medicaid under the present subchapter, cost-of-living increases in OASDI paid under section 215(i) of the Social Security Act after April, 1977, are no longer excluded from but are counted as unearned income.

(iv) This group does not include individuals who in December, 1973, were eligible for medicaid as an essential spouse of a recipient of OAA, AB, APTD, or AABD. These individuals are eligible for medicaid under subchapter 9 if the provisions of ARM 37.82.901(4)(a), 37.82.902(4), and 37.82.903(4) are met. When medicaid under subchapter 9 is lost, such individuals must qualify for medicaid under the present subchapter in their own right. Medicaid under the present subchapter does not provide for coverage of an essential person.

(v) This group does not include individuals who would be eligible for SSI had they applied. These individuals are not relevant to medicaid under this subchapter.

(b) Individuals who, under ARM 37.82.901(4)(b) and 37.82.903(4), would be eligible for medicaid under subchapter 9, on the basis of December, 1973, blindness or disability criteria, if their income had not exceeded the income standards specified in ARM 37.82.903(4). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1991 MAR p. 265, Eff. 3/1/91; AMD, 1991 MAR p. 1046, Eff. 6/28/91; AMD, 1993 MAR p. 1398, Eff. 7/1/93; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1102 NON-FINANCIAL REQUIREMENTS, NON-INSTITUTIONALIZED MEDICALLY NEEDY (1) Except as provided in (2), for groups covered under ARM 37.82.1101(1), the AFDC nonfinancial requirements which are set forth in ARM 46.10.301 through 46.10.307, 46.10.320 and 46.10.321 will be used to determine whether:

(a) an individual under age 19 is considered a dependent child because he is deprived of parental support or care;

(b) an individual is an eligible member of a family with a dependent child; and

(c) notwithstanding the above and in accordance with ARM 37.82.1101(1)(c), (d), and (e), the school attendance requirement found in ARM 46.10.301 and the JOBS participation requirements found in ARM 46.10.805 through 46.10.847 do not apply to this coverage group.

(2) In the case of individuals under 21 who are ineligible for medicaid under ARM 37.82.701(1)(b)(iii) and (3), the nonfinancial requirements for medicaid under this subchapter are as provided in ARM 37.82.701(3).

(3) Except as provided in (4), for groups under non-institutionalized SSI-related individuals and couples, the SSI nonfinancial requirements which are set forth in 20 CFR, part 416, subparts H and I, will be used to determine whether an individual is aged, blind or disabled.

(a) 20 CFR part 416, subpart H, contains the SSI criteria for determining age.

(b) 20 CFR part 416, subpart I, contains the SSI criteria for determining blindness and disability.

(c) The department hereby adopts and incorporates by reference 20 CFR part 416, subparts H and I. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(4) For individuals who, under ARM 37.82.1101(2)(b), may meet the December 1973 blindness or disability criteria instead of the current SSI criteria, see ARM 37.82.902(4) for these. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1991 MAR p. 265, Eff. 3/1/91; TRANS, from SRS, 2000 MAR p. 476.)

Rules 03 through 05 reserved

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37.82.1106 MEDICALLY NEEDY INCOME STANDARDS (1) To be eligible for medically needy assistance, SSI and family-related institutionalized and non-institutionalized recipients must meet:

(a) non-financial criteria of ARM 37.82.1102;

(b) resource criteria of ARM 37.82.1110; and

(c) income criteria of ARM 37.82.1107.

(2) Medically needy recipients must participate in cost sharing as provided for in ARM 37.85.204.

(3) The adjusted income for individuals and families is compared to the following table to determine medically needy assistance eligibility.

(a) Since families who are not residing in an institution are assumed to have a shelter obligation, an amount for shelter obligation is included in each level.

(b) Institutionalized recipients must also meet the income criteria of ARM 37.82.1320.

MEDICALLY NEEDY INCOME LEVELS
FOR SSI and FAMILY-RELATED
INDIVIDUALS AND FAMILIES

Family Size	One Month Net Income Level
1	$ 525
2	525
3	658
4	792
5	925
6	1,058
7	1,192
8	1,317
9	1,383
10	1,450
11	1,508
12	1,558
13	1,608
14	1,658
15	1,700
16	1,742

(History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1981 MAR p. 769, Eff. 7/31/81; AMD, 1982 MAR p. 105, Eff. 1/29/82; AMD, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1982 MAR p. 1280, Eff. 7/1/82; AMD, 1983 MAR p. 757, Eff. 7/1/83; EMERG, AMD, 1983 MAR p. 1933, Eff. 1/1/84; AMD, 1984 MAR p. 328, Eff. 2/17/84; AMD, 1985 MAR p. 181, Eff. 2/15/85; AMD, 1985 MAR p. 1027, Eff. 7/26/85; AMD, 1985 MAR p. 2051, Eff. 12/27/85; AMD, 1987 MAR p. 163, Eff. 2/14/87; AMD, 1987 MAR p. 1346, Eff. 8/14/87; AMD, 1987 MAR p. 2172, Eff. 11/28/87; AMD, 1987 MAR p. 2397, Eff. 1/1/88; AMD, 1989 MAR p. 232, Eff. 1/27/89; AMD, 1990 MAR p. 853, Eff. 4/27/90; AMD, 1990 MAR p. 1334, Eff. 7/13/90; AMD, 1991 MAR p. 265, Eff. 3/1/91; AMD, 1991 MAR p. 1050, Eff. 6/28/91; AMD, 1992 MAR p. 1405, Eff. 7/1/92; AMD, 1992 MAR p. 2398, Eff. 10/30/92; AMD, 1993 MAR p. 1398, Eff. 7/1/93; AMD, 1994 MAR p. 1750, Eff. 7/1/94; AMD, 1995 MAR p. 1246, Eff. 7/1/95; AMD, 1997 MAR p. 502, Eff. 3/11/97; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2002 MAR p. 1773, Eff. 6/28/02.)

37.82.1107 INCOME ELIGIBILITY, NON-INSTITUTIONALIZED MEDICALLY NEEDY (1) Medically needy income eligibility for SSI and family-related persons and families will be computed using a one month prospective budget period.

(a) For groups covered under ARM 37.82.1101(1)(a) through (1)(e), monthly countable income will be determined using family-related medicaid income requirements, in particular those with respect to prospective budgeting and earned income disregards, set forth in the family medicaid manual, sections 601-1 and 602-1.

(i) In the case of individuals whose income must be deemed when determining eligibility, the family-related medicaid income requirements contained in the family medicaid manual, section 603-1 will be used.

(ii) In the case of individuals under age 21 who reside in an inpatient psychiatric facility, only income which belongs to the individual or which is actually contributed to the individual will be used to determine eligibility.

(b) For groups covered under ARM 37.82.1101(4)(a) and (b), countable income will be determined using the SSI income requirements set forth in 20 CFR, part 416, subpart K, as amended through April 1, 2001, which contains the SSI criteria for evaluating income, including the income of financially responsible relatives. The department hereby adopts and incorporates by reference 20 CFR, part 416, subpart K, as amended through April 1, 2001. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(i) The exemption from the income requirements relating to financially responsible relatives as described at ARM 37.82.903(2)(b) applies to individuals applying as medically needy.

(2) When an otherwise eligible family, individual or couple covered under ARM 37.82.1101 has countable income equal to or less than the applicable medically needy income level, the family, individual or couple is eligible for medicaid without an incurment of medical expenses.

(3) When an otherwise eligible individual or family covered under ARM 37.82.1101 has countable income which exceeds the medically needy income level, the individual or family will become eligible:

(a) on the first day of the month if the individual or family pays the cost-share amount for the month in cash to the department, eligibility begins on the first day of the month. The cost-share amount is equal to the difference between the individual's or family's countable income and the medically needy income level for that household size;

(i) Medical expenses may be used to reduce the cost-share amount. The only medical expenses which may be used are:

(A) expenses incurred by:

(I) eligible or ineligible individuals who are considered members of the household for family-medicaid; or

(II) eligible individuals or the eligible individual's spouse if there was income deemed from the spouse to the eligible individual for SSI related medicaid.

(B) expenses which are not the liability of a third party other than another public program of the state of Montana;

(C) expenses which have not been used to meet a prior incurment or used to reduce the cost-share amount in a prior period;

(D) expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under state law but are not Montana medicaid covered services; or

(b) after a medical expense incurment is satisfied. The incurment is equal to the difference between the countable income and the medically needy income limit for the family size. Eligibility will extend to the end of the budget period. The only medical expenses which may be used to meet the incurment requirement are:

(i) expenses incurred by:

(A) eligible or ineligible individuals who are considered members of the household for family-related medicaid; or

(B) eligible individuals or the eligible individual's spouse if there was income deemed from the spouse to the eligible individual for SSI related medicaid.

(ii) expenses which are not the liability of a third party other than another public program of the state of Montana or any of its political subdivisions;

(iii) expenses which have not been used to meet a prior incurment requirement;

(iv) expenses will be deducted in the following order:

(A) medicare and other health insurance premiums, deductibles, or coinsurance charges;

(B) expenses for necessary medical and remedial services that are recognized under Montana law but are not provided for under this chapter;

(C) expenses for necessary medical and remedial services that are provided for under this chapter.

(v) for the retroactive budget period:

(A) paid and unpaid expenses incurred during the retroactive budget period; and

(B) paid or unpaid bills incurred in the three months immediately prior to the retroactive budget period.

(vi) for the prospective budget period:

(A) paid and unpaid expenses incurred during the three months immediately preceding the prospective budget period;

(B) paid and unpaid expenses incurred during the prospective budget period.

(4) Medicaid will pay only unpaid medical expenses:

(a) incurred by an eligible individual in the retroactive or prospective budget period;

(b) which have never been used to meet an incurment requirement;

(c) provided for under this chapter; and

(d) for which no third party payment is available.

(5) An unborn child is considered a family member when determining medicaid eligibility.

(6) A medically needy individual or family who paid the cost-share obligation but did not incur medical expenses equal to that cost-share obligation may request a refund of funds which exceed the provider billed charges. (History: Sec. 53-2-201, 53-4-212, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-4-231, 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1983 MAR p. 1079, Eff. 8/15/83; AMD, 1986 MAR p. 678, Eff. 4/25/86; AMD, 1987 MAR p. 1655, Eff. 9/25/87; AMD, 1991 MAR p. 265, Eff. 3/1/91; AMD, 1993 MAR p. 1398, Eff. 7/1/93; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2000 MAR p. 746, Eff. 3/17/00; AMD, 2002 MAR p. 1773, Eff. 6/28/02.)

Rules 08 and 09 reserved

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37.82.1110 RESOURCE STANDARDS, NON-INSTITUTIONALIZED MEDICALLY NEEDY (1) Except as provided in (2) for households receiving assistance in the FAIM project, the medically needy resource limitations are:

Family Size	
1	$2,000
2	3,000

(a) One hundred dollars will be added to the two person standard for each additional family member.

(2) For households receiving assistance in the FAIM project, the medically needy resource limitation is $3,000 regardless of the number of members in the household.

(3) To establish resource eligibility for the medically needy program:

(a) FAIM financial assistance related individuals and families will have resources evaluated according to ARM 46.18.118. The value of the resources must not exceed the resource limit under (1) as of the date of application to be eligible for any part of the month.

(b) SSI related individuals will have resources evaluated according to 20 CFR part 416, subpart L, as amended through April 1, 1990. The department hereby adopts and incorporates by reference 20 CFR, part 416, subpart L, as amended through April 1, 1990. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952. SSI-related applicants must be within the applicable resource limit under (1) on the first moment of the first day of the coverage month.

(4) The exemption from the resource requirements relating to financially responsible relatives as described at ARM 37.82.903(2)(b) applies to individuals applying as medically needy. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 678, Eff. 4/25/86; AMD, 1991 MAR p. 265, Eff. 3/1/91; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1111 THREE MONTH RETROACTIVE COVERAGE, NON-INSTITUTIONALIZED MEDICALLY NEEDY (1) The retroactive period may include any or all of the three months immediately preceding the month of application.

(2) To be eligible for retroactive medically needy coverage, during each month of the retroactive period, SSI and AFDC-related persons and families must meet:

(a) non-financial criteria of ARM 37.82.1102;

(b) resource criteria of ARM 37.82.1110 as of the first day of the month; and

(c) income criteria of ARM 37.82.1107 except that income will be determined using actual income received in the retroactive period.

(3) Medical expenses incurred during the retroactive period will be paid according to ARM 37.82.1107(4). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1991 MAR p. 265, Eff. 3/1/91; AMD, 1998 MAR p. 3281, Eff. 12/18/98; TRANS, from SRS, 2000 MAR p. 476.)

Subchapter 12 reserved

Subchapter 13

Eligibility Requirements for the Institutionalized Categorically Needy and Medically Needy

37.82.1301 DEFINITIONS RELATING TO INSTITUTIONAL STATUS

(1) As used in this subchapter:

(a) "Active treatment in institutions for the mentally retarded" requires the following:

(i) The individual's regular participation, in accordance with an individual plan of care, in professionally developed and supervised activities, experiences, or therapies.

(ii) An individual written plan of care that sets forth measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social, or vocational level he can presently or potentially achieve.

(iii) An interdisciplinary professional evaluation that:

(A) is completed for a recipient, before admission to the institution but not more than three months before, and for an individual applying for medicaid after admission, before the institution requests payment;

(B) consists of complete medical, social and psychological diagnosis and evaluations and an evaluation of the individual's need for institutional care; and

(C) is made by a physician, a social worker and other professionals, at least one of whom is a qualified mental retardation professional.

(iv) Reevaluation medically, socially and psychologically at least annually by the staff involved in carrying out the resident's individual plan of care. This must include review of the individual's progress toward meeting the plan objectives, the appropriateness of the individual plan of care, assessment of his continuing need for institutional care, and consideration of alternate methods of care.

(v) An individual postinstitutional plan, as part of the individual plan of care, developed before discharge by a qualified mental retardation professional and other appropriate professionals. This must include provision for appropriate services, protective supervision, and other follow-up services in the resident's new environment.

(b) "In an institution" refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

(c) "Inmate of a public institution" means a person who is living in a public institution. An individual is not considered an inmate if:

(i) he is in a public educational or vocational training institution for purposes of securing education or vocational training; or

(ii) he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

(d) "Inpatient" means a patient who has been admitted to a medical institution on recommendation of a physician or dentist and is receiving room board, and professional services in the institution on a continuous 24-hour-a-day basis.

(e) "Institution" means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

(f) "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

(g) "Institution for the mentally retarded or persons with related conditions" means an institution (or distinct part of an institution) that:

(i) is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

(ii) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

(h) "Institution for tuberculosis" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

(i) "Medical institution" means an institution that:

(i) is organized to provide medical care, including nursing and convalescent care;

(ii) has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(iii) is certified under Montana law to provide medical care; and

(iv) is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

(j) "Patient" means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability or pain.

(k) "Persons with related conditions" means individuals who have epilepsy, cerebral palsy, or other developmental disabilities.

(l) "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include a medical institution as defined above, an intermediate care facility as defined in chapter 40, subchapter 3, or a publicly operated community residence that serves no more than 16 residents, as defined below.

(m) "Publicly operated community residence that serves no more than 16 residents" means:

(i) It is the responsibility of a governmental unit, or a governmental unit exercises administrative control over it.

(ii) It has been designed or has been changed to serve no more than 16 residents and it is serving no more than 16.

(iii) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided.

(iv) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:

(A) residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex;

(B) educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there;

(C) correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles;

(D) hospitals, skilled nursing facilities, and intermediate care facilities.

(n) "Resident of an intermediate care facility" is an individual who is:

(i) in need of and receiving professional services to maintain, improve, or protect health or lessen disability or pain under the direction of a practitioner of the healing arts;

(ii) admitted to an intermediate care facility in accordance with chapter 40, subchapter 1;

(iii) under care and supervision 24-hours-a-day; and

(iv) if he is in an institution for the mentally retarded, receiving active treatment as defined above. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Rules 02 through 04 reserved

NEXT PAGE IS 37-18635

37.82.1305 GROUPS COVERED, AFDC-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Medicaid will be provided to the following AFDC-related institutionalized individuals under the heading categorically needy:

(a) Individuals under age 21 in intermediate care facilities, including in intermediate care facilities for the mentally retarded.

(b) Individuals under age 21 receiving active treatment as inpatients in psychiatric facilities or programs provided that the youth is in the custody of the department or has been committed to the department by district court pursuant to 41-3-403, 41-3-404, 41-3-406 or 41-5-523, MCA.

(2) Medicaid will also be provided to the following AFDC-related institutionalized individuals under the heading medically needy:

(a) individuals described in (1)(a) and (1)(b) who are ineligible for coverage as categorically needy because of excess income. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1993 MAR p. 1399, Eff. 6/25/93; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1306 GROUPS COVERED, SSI-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Medicaid will be provided to the following SSI-related institutionalized individuals under the heading categorically needy:

(a) Individuals receiving SSI on the basis of the SSI income standard for institutionalized individuals.

(b) Individuals in medical institutions and intermediate care facilities who are ineligible for SSI because the SSI income standard for institutionalized individuals is lower than the SSI income standard for noninstitutionalized individuals.

(c) Individuals who were eligible for medicaid in December, 1973, as inpatients of medical institutions or residents of intermediate care facilities, if, for each consecutive month after December, 1973, they:

(i) continue to meet the December, 1973, eligibility requirements;

(ii) remain institutionalized; and

(iii) continue to need institutional care.

(2) Medicaid will also be provided to the following SSI-related institutionalized individuals under the heading medically needy:

(a) individuals described in (1)(b) who are ineligible for coverage as categorically needy because of excess income. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Rules 07 through 09 reserved

37.82.1310 NON-FINANCIAL REQUIREMENTS, AFDC-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Individuals under age 19 who continue to receive AFDC even though they are in a medical institution or intermediate care facility are presumed to have met the non-financial requirements for medicaid eligibility.

(2) For individuals under age 21 in intermediate care facilities, including intermediate care facilities for the mentally retarded, or receiving treatment in psychiatric facilities or programs pursuant to the requirements of ARM 37.82.1305(1)(b), the nonfinancial requirements for medicaid under this subchapter, whether as categorically needy or medically needy, consist of the age requirement and applicable service requirements. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1993 MAR p. 1399, Eff. 6/25/93; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1311 NON-FINANCIAL REQUIREMENTS, SSI-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Individuals receiving SSI on the basis of the SSI income standard for institutionalized individuals are presumed to have met the nonfinancial requirements for medicaid eligibility.

(2) For individuals in medical institutions and intermediate care facilities who are ineligible for SSI because the SSI income standard for institutionalized individuals is lower than the SSI income standard for noninstitutionalized individuals, the nonfinancial requirements for medicaid under this subchapter, whether as categorically needy or medically needy, are the SSI nonfinancial requirements which are set forth in 20 CFR, Part 416, subparts H and I. These will be used to determine whether an individual is aged, blind, or disabled. 20 CFR, Part 416, subpart H, contains the SSI criteria for determining age, and 20 CFR, Part 416, subpart I, contains the SSI criteria for determining blindness and disability. The department hereby adopts and incorporates 20 CFR, Part 416, subparts H and I. A copy of these federal regulations may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952.

(3) For individuals who were eligible for medicaid in December, 1973, as inpatients of medical institutions or residents of intermediate care facilities, the nonfinancial requirements for medicaid under this subchapter are the December, 1973 OAA, AB, APTD, or AABD nonfinancial requirements. A copy of the December, 1973 OAA, AB, APTD, and AABD nonfinancial requirements may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1312 FINANCIAL REQUIREMENTS, AFDC-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Individuals under age 19 who continue to receive AFDC even though they are in a medical institution or intermediate care facility are presumed to have met the financial requirements for medicaid eligibility.

(2) For individuals under age 21 in intermediate care facilities, including intermediate care facilities for the mentally retarded, or receiving treatment in psychiatric facilities or programs pursuant to the requirements of ARM 37.82.1305(1)(b), the financial requirements for medicaid under this subchapter as categorically needy are the AFDC financial requirements which are set forth in ARM 46.10.401 through 46.10.406 and 46.10.505 through 46.10.514. These will be used to determine whether:

(a) the individual in his placement is eligible with respect to resources;

(b) the individual in his placement is eligible with respect to gross and net income and with respect to the applicable benefit standards.

(c) In applying the above;

(i) because the individual is not living with his parent, parental income will be considered only when actually contributed; and

(ii) applicable standards are the child only standards.

(3) For individuals under age 21 in intermediate care facilities, including intermediate care facilities for the mentally retarded, or receiving treatment in psychiatric facilities or programs pursuant to the requirements of ARM 37.82.1305(1)(b) who are ineligible under (2) because of excess income, the financial requirements for medicaid under this subchapter as medically needy are the medically needy financial requirements for noninstitutionalized AFDC-related families and children which are set forth in subchapter 11. The financial provisions of this subchapter which apply to individuals under 21 who are ineligible for medicaid under ARM 37.82.701(1)(b)(iii) and (3) apply identically to the above described individuals under 21. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1993 MAR p. 1399, Eff. 6/25/93; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1313 FINANCIAL REQUIREMENTS, SSI-RELATED INSTITUTIONALIZED INDIVIDUALS (1) Individuals receiving SSI on the basis of the SSI income standard for institutionalized individuals are presumed to have met the financial requirements for medicaid eligibility.

(2) For individuals in medical institutions and intermediate care facilities who are ineligible for SSI because the SSI income standard for institutionalized individuals is lower than the SSI income standards for noninstitutionalized individuals, the financial requirements for medicaid under this subchapter as categorically needy are the categorically needy financial requirements for noninstitutionalized SSI-related individuals and couples which are set forth in subchapter 9. The provisions of this subchapter, in particular those which apply to the individual living in his own home, apply identically to the above described individual.

(3) For individuals in medical institutions and intermediate care facilities who are ineligible under (2) because of excess income, the financial requirements for medicaid under this subchapter as medically needy are the medically needy financial requirements for noninstitutionalized SSI-related individuals and couples which are set forth in subchapter 11. The financial provisions of this subchapter which apply to the individual living in his own home apply identically to the above described individual.

(4) For individuals who were eligible for medicaid in December, 1973, as inpatients of medical institutions or residents of intermediate care facilities, the financial requirements for medicaid under this subchapter are the December, 1973 OAA, AB, APTD, or AABD financial requirements. A copy of the December, 1973, OAA, AB, APTD, and AABD financial requirements may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, Public Assistance Bureau, Cogswell Building, 1400 Broadway, P.O. Box 202952, Helena, MT 59620-2952. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Rules 14 through 19 reserved

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37.82.1320 POST-ELIGIBILITY APPLICATION OF PATIENT INCOME TO COST OF CARE (1) After the non-financial and resource eligibility criteria are met, the income of individuals in a residential medical institution will be applied toward the cost of care as provided in this section. This provision applies to all covered groups in this subchapter, except:

(a) individuals under age 19 who continue to receive AFDC even though they are in a medical institution or intermediate care facility, as provided in ARM 37.82.1305(1)(a); and

(b) individuals receiving supplemental security income on the basis of the supplemental security income standard for institutional individuals, as provided in ARM 37.82.1306(1)(a).

(2) Amounts will be deducted from a single individual's gross income in the following order to determine the amount applicable toward his cost of care:

(a) up to $65 of gross earned income;

(b) a personal needs allowance of:

(i) $90 for veterans receiving the minimum veterans administration pension; or

(ii) $40 for all other individuals.

(c) a home maintenance allowance, when applicable, determined in accordance with (7).

(d) medical or remedial care expenses of the institutionalized individual as defined in (8).

(3) During any month in which an institutionalized spouse is in the institution, no income of the community spouse may be deemed available to the institutionalized spouse except as specifically provided in this section.

(a) In determining whether any income, including income from a trust or from any other source, is income of the institutionalized or community spouse after the institutionalized spouse has been determined eligible for medical assistance, the following rules shall apply regardless of state law regarding the division of marital property to the contrary:

(i) income from a trust or other written agreement shall be considered available according to the terms of the trust or agreement; or

(ii) if there is no trust or written agreement making provision for distribution of income, the income shall be considered available according to the manner in which it is distributed.

(b) The rules in (3) shall not apply, unless otherwise made applicable under state or federal law, to determinations of an individual's interest in any income or resource under any public assistance or medical assistance program to individuals who are not institutionalized or community spouses.

(4) The following amounts will be deducted monthly in the following order from the gross income of an institutionalized spouse to determine the amount applicable toward the cost of care:

(a) up to $65 of gross earned income;

(b) $40 personal needs allowance for the institutionalized spouse;

(c) a monthly income allowance for the community spouse determined in accordance with (9);

(d) a family allowance for each family member equal to one-third of the difference between the basic needs standard, as determined under (9)(b)(i)(A) through (C) of this rule, and the family member's gross monthly income;

(e) incurred medical or remedial care expenses of the institutionalized spouse as defined in (8); and

(f) Regardless of any other provision of this section, the community spouse's monthly income allowance as defined in (9) of this rule shall not be less than the amount of any monthly support which an institutionalized spouse has been ordered by a court to pay to the community spouse.

(5) The institutionalized spouse or his representative is responsible to report to the department any changes to his own and the community spouse's income within 10 days of the change.

(6) Unless the institutionalized spouse specifically objects, a community spouse monthly income allowance will be deducted from the institutionalized spouse's monthly income and provided to the community spouse.

(7) The home maintenance allowance for purposes of (2)(c) of this rule shall consist of the greater of the following:

(a) an amount for each dependent family member equal to one-third the difference between the basic needs standard, as determined according to (9)(b)(i)(A) through (C) of this rule, and the family member's gross monthly income;

(b) the medically needy income level for one as defined in ARM 37.82.1106 if the client:

(i) entered the facility from a community living arrangement after the first day of the month; or

(ii) leaves the facility into a community living arrangement on or before the last day of the month;

(c) for a maximum of 6 months, the medically needy income level for one as defined in ARM 37.82.1106 when a physician certifies that the individual is likely to return to the home within 6 months.

(8) Medical or remedial care expenses of the institutionalized individual for purposes of (2)(d) and (4)(e) of this rule include:

(a) medicare and other health insurance premiums, deductibles or coinsurance;

(b) for three months or until paid in full, whichever comes first, medical or remedial care expenses which:

(i) were incurred during the three months prior to application;

(ii) were unpaid at the time of application; and

(iii) are not payable by a third party;

(c) medical expenses incurred by the institutionalized individual which are:

(i) for services or items prescribed by a physician;

(ii) not for a medicaid covered service or item; and

(iii) not payable by a third party.

(9) A monthly income allowance for the community spouse for purposes of (4)(c) of this rule shall consist of the lesser of:

(a) $1,500 minus the community spouse's own gross monthly income. Effective January 1 of each calendar year after 1989 the $1,500 limit will increase by a percentage equal to the increase in the consumer price index for all urban consumers which occurred between September of the calendar year for which the increase is being made and September of the preceding year; or

(b) the total of:

(i) a basic needs standard which is equal to:

(A) 1/12 of 122% of the federal poverty level for a family unit of two persons effective through June 30, 1991;

(B) 1/12 of 133% of the federal poverty level for a family unit of two persons from July 1, 1991 through June 30, 1992;

(C) 1/12 of 150% of the federal poverty level for a family unit of two persons beginning July 1, 1992; plus

(ii) shelter expenses as defined in ARM 37.82.1330 which exceed 30% of the amount determined under (9)(b)(i); minus

(iii) the amount of gross monthly income otherwise available to the community spouse, without regard to the community spouse's monthly income allowance. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1990 MAR p. 543, Eff. 3/16/90; AMD, 1991 MAR p. 54, Eff. 1/18/91; AMD, 1992 MAR p. 673, Eff. 3/27/92; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1321 PROHIBITED COVERAGE (1) Medicaid will not be provided to:

(a) an individual who is an inmate of a public institution;

(b) an individual who is a patient under age 65 in an institution for tuberculosis or mental disease except as an inpatient receiving active treatment in a psychiatric facility or program. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; TRANS, from SRS, 2000 MAR p. 476.)

Rules 22 through 29 reserved

37.82.1330 INSTITUTIONALIZED SPOUSE, DEFINITIONS (1) The following definitions apply with respect to ARM 37.82.1320, 37.82.1321, 37.82.1330, 37.82.1331, and 37.82.1336 through 37.82.1338.

(a) "Community spouse" is the member of the married couple who continues to reside in the community after the institutionalization of the other spouse.

(b) "Community spouse resource allowance" means the amount of the couple's combined countable resources which are transferrable to the community spouse, as determined under ARM 37.82.1336.

(c) "Continuous period of institutionalization" means at least 30 consecutive days of institutionalization without a break in care.

(d) "Countable resources" are those resources defined as countable in ARM 37.82.903(2).

(e) "Dependent" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse and are recognized as dependents for federal income tax purposes.

(f) "Institutionalization" means admission to a medical institution.

(g) "Institutionalized spouse" means an individual who:

(i) is in a medical institution or nursing facility;

(ii) is married to a spouse who is not in a medical institution or nursing facility; and

(iii) is likely to meet conditions (i) and (ii) of this definition for at least 30 consecutive days.

(h) "Medical institution" means an institution organized to provide medical care and includes, but is not limited to, hospitals and nursing facilities.

(i) "Shelter expenses" means the following expenses for the community spouse's principal residence:

(i) the monthly amount of rent or mortgage payment, including principal and interest;

(ii) real estate taxes on the community spouse's principal residence;

(iii) homeowners insurance on the community spouse's principal residence;

(iv) any required condominium or cooperative maintenance charge on the community spouse's principal residence; and

(v) a monthly standard utility allowance (SUA) available only to households which incur central heating or central cooling costs separate from rent or mortgage. The SUA shall be $225 and includes the cost of heating or cooling, water, sewerage, garbage and trash collections, cooking fuel, electricity not used to heat or cool the residence, and the basic service fee for a telephone. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1991 MAR p. 54, Eff. 1/18/91; AMD, 1992 MAR p. 673, Eff. 3/27/92; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1331 INSTITUTIONALIZED SPOUSE, RESOURCE ASSESSMENTS

(1) A resource assessment is available to any married individual who:

(a) entered a medical institution on or after October 1, 1989;

(b) is likely to remain in the institution for at least 30 consecutive days; and

(c) has a spouse who continues to reside in the community.

(2) Only one resource assessment per lifetime is available to each institutionalized spouse. The resource assessment is based on the couple's countable resources at the beginning of the first period of continuous institutionalization beginning after September 30, 1989.

(3) An institutionalized spouse, community spouse or a representative for either spouse may request a resource assessment based on the married couple's combined countable resources, whether owned individually or jointly, as of the first moment of the month of institutionalization.

(4) The individual requesting the assessment must provide all relevant documentation and/or verification required by the department within 45 days of the assessment request date.

(5) The department will complete a resource assessment within 45 days of:

(a) the assessment request date, unless documentation or verification is delayed due to a third party; or

(b) documentation or verification receipt when the individual requesting the resource assessment does not provide necessary information in a timely manner.

(6) When the resource assessment is complete the department will provide written notice to both spouses including:

(a) the amount of the combined countable resources at the beginning of the most recent continuous period of institutionalization;

(b) the method used to compute the community spouse's resource allowance ARM 37.82.1336(2); and

(c) the method used to compute the amount of resources available to the institutionalized spouse.

(7) The resource assessment is appealable through a fair hearing by either spouse after the institutionalized spouse applies for medicaid benefits, and the hearing must be held within 30 days of the date it is requested. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1991 MAR p. 54, Eff. 1/18/91; TRANS, from SRS, 2000 MAR p. 476.)

Rules 32 through 35 reserved

37.82.1336 INSTITUTIONALIZED SPOUSE, RESOURCE ELIGIBILITY DETERMINATION (1) The institutionalized spouse is resource eligible when the institutionalized spouse and community spouse's combined countable resources are less than or equal to the community spouse's resource allowance in (2) plus the supplemental security income (SSI) resource limitation for one person as defined in ARM 37.82.1110.

(2) The community spouse resource allowance is the greatest of the following:

(a) one-half, but no more than $60,000, of the couple's combined countable resources. Effective January 1 of each calendar year after 1989, the $60,000 limit shall increase by the same percentage increase in the consumer price index as adopted by the federal government for all urban consumers which occurred between September 1988 and the September before the calendar year involved;

(b) Montana's standard community spouse resource allowance of $12,000. Effective January 1 of each calendar year after 1989, the $12,000 limit shall increase by the same percentage increase in the consumer price index as adopted by the federal government for all urban consumers which occurred between September 1988 and the September before the calendar year involved;

(c) an amount established under a court order; or

(d) an amount designated by a department hearings officer.

(3) The community spouse resource allowance must be revised when inaccurate information was used to calculate the resource allowance.

(4) After the month in which the institutionalized spouse is determined eligible for medicaid, no resources of the community spouse shall be deemed available to the institutionalized spouse as long as the institutionalized spouse remains continuously institutionalized.

(5) Eligibility will not be denied an institutionalized spouse whose resources exceed the supplemental security income resource limit for one when denial of eligibility will create an undue hardship or when the conditions of assignment of support rights described in 42 U.S.C. 1396r-5(c)(3)(A) and (B) (sub 1990 edition) are met. The department hereby adopts and incorporates 42 U.S.C. 1396r-5(c)(3)(A) and (B) (sub 1990 edition) by reference. Copies may be obtained through the Department of Public Health and Human Services, Operations and Technologies Division, Institutional Reimbursement, 111 Sanders, P.O. Box 6429, Helena, MT 59604-6429.

(6) Unless specifically refused by the institutionalized spouse, a portion or all of his resources may be used to ensure adequate resources are available to meet the community spouse resource allowance. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1991 MAR p. 54, Eff. 1/18/91; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1337 INSTITUTIONALIZED SPOUSE, RECEIPT OF ADDITIONAL RESOURCES (1) When additional resources are received by an institutionalized spouse after the initial eligibility determination and receipt of such resources would cause ineligibility for the institutionalized spouse, the resources will be exempt as countable resources for 90 days from receipt if:

(a) the institutionalized spouse intends to transfer the new resources to the community spouse;

(b) receipt of the additional resources is reported within ten days of receipt; and

(c) a written statement of the intent to transfer the resources to the community spouse is made by the institutionalized spouse. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1991 MAR p. 54, Eff. 1/18/91; TRANS, from SRS, 2000 MAR p. 476.)

37.82.1338 INSTITUTIONALIZED SPOUSE, TRANSFER OF RESOURCES TO COMMUNITY SPOUSE (1) Within 90 days of the initial eligibility determination or court order, or within any time period specifically required under the court order, an institutionalized spouse must irrevocably transfer resources:

(a) to or for the sole benefit of the community spouse resources which constitute the community spouse's resource allowance; or

(b) to or for the sole benefit of the community spouse or a family member, if such transfer is pursuant to a court order. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-131, MCA; NEW, 1991 MAR p. 54, Eff. 1/18/91; TRANS, from SRS, 2000 MAR p. 476.)